

106TH CONGRESS
2D SESSION

H. R. _____

IN THE HOUSE OF REPRESENTATIVES

Mr. THOMAS (for himself, Mr. BLILEY, and Mr. BILIRAKIS) introduced the following bill; which was referred to the Committee on

A BILL

To amend titles XVIII, XIX, and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the medicare and medicaid programs and the State child health insurance program (SCHIP), as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

1 *Be it enacted by the Senate and House of Representatives*
2 *of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SE-**
 2 **CURITY ACT; REFERENCES TO OTHER ACTS;**
 3 **TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the “Medi-
 5 care, Medicaid, and SCHIP Benefits Improvement and Protec-
 6 tion Act of 2000”.

7 (b) **AMENDMENTS TO SOCIAL SECURITY ACT.**—Except as
 8 otherwise specifically provided, whenever in this Act an amend-
 9 ment is expressed in terms of an amendment to or repeal of
 10 a section or other provision, the reference shall be considered
 11 to be made to that section or other provision of the Social Se-
 12 curity Act.

13 (c) **REFERENCES TO OTHER ACTS.**—In this Act:

14 (1) **BALANCED BUDGET ACT OF 1997.**—The term
 15 “BBA” means the Balanced Budget Act of 1997 (Public
 16 Law 105–33; 111 Stat. 251).

17 (2) **MEDICARE, MEDICAID, AND SCHIP BALANCED**
 18 **BUDGET REFINEMENT ACT OF 1999.**—The term “BBRA”
 19 means the Medicare, Medicaid, and SCHIP Balanced
 20 Budget Refinement Act of 1999 (Appendix F, 113 Stat.
 21 1501A–321), as enacted into law by section 1000(a)(6) of
 22 Public Law 106–113.

23 (d) **TABLE OF CONTENTS.**—The table of contents of this
 24 Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to other
 Acts; table of contents.

TITLE I—MEDICARE BENEFICIARY IMPROVEMENTS

Subtitle A—Improved Preventive Benefits

- Sec. 101. Coverage of biennial screening pap smear and pelvic exams.
- Sec. 102. Coverage of screening for glaucoma.
- Sec. 103. Coverage of screening colonoscopy for average risk individuals.
- Sec. 104. Modernization of screening mammography benefit.
- Sec. 105. Coverage of medical nutrition therapy services for beneficiaries
 with diabetes or a renal disease.

Subtitle B—Other Beneficiary Improvements

- Sec. 111. Acceleration of reduction of beneficiary copayment for hospital
 outpatient department services.
- Sec. 112. Preservation of coverage of drugs and biologicals under part B
 of the medicare program.
- Sec. 113. Elimination of time limitation on medicare benefits for immuno-
 suppressive drugs.
- Sec. 114. Imposition of billing limits on prescription drugs.

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Subtitle C—Demonstration Projects and Studies

- Sec. 121. Demonstration project for disease management for severely chronically ill medicare beneficiaries.
- Sec. 122. Cancer prevention and treatment demonstration for ethnic and racial minorities.
- Sec. 123. Study on medicare coverage of routine thyroid screening.
- Sec. 124. MedPAC study on consumer coalitions.
- Sec. 125. Study on limitation on State payment for medicare cost-sharing affecting access to services for qualified medicare beneficiaries.
- Sec. 126. Institute of Medicine study on waiver of 24-month waiting period for medicare disability eligibility for amyotrophic lateral sclerosis (ALS) and other devastating diseases.
- Sec. 127. Studies on preventive interventions in primary care for older Americans.
- Sec. 128. MedPAC study and report on medicare coverage of cardiac and pulmonary rehabilitation therapy services.

TITLE II—RURAL HEALTH CARE IMPROVEMENTS

Subtitle A—Critical Access Hospital Provisions

- Sec. 201. Clarification of no beneficiary cost-sharing for clinical diagnostic laboratory tests furnished by critical access hospitals.
- Sec. 202. Assistance with fee schedule payment for professional services under all-inclusive rate.
- Sec. 203. Exemption of critical access hospital swing beds from SNF PPS.
- Sec. 204. Payment in critical access hospitals for emergency room on-call physicians.
- Sec. 205. Treatment of ambulance services furnished by certain critical access hospitals.
- Sec. 206. GAO study on certain eligibility requirements for critical access hospitals.

Subtitle B—Other Rural Hospitals Provisions

- Sec. 211. Equitable treatment for rural disproportionate share hospitals.
- Sec. 212. Option to base eligibility for medicare dependent, small rural hospital program on discharges during 2 of the 3 most recently audited cost reporting periods.
- Sec. 213. Extension of option to use rebased target amounts to all sole community hospitals.
- Sec. 214. MedPAC analysis of impact of volume on per unit cost of rural hospitals with psychiatric units.

Subtitle C—Other Rural Provisions

- Sec. 221. Assistance for providers of ambulance services in rural areas.
- Sec. 222. Payment for certain physician assistant services.
- Sec. 223. Revision of medicare reimbursement for telehealth services.
- Sec. 224. Expanding access to rural health clinics.
- Sec. 225. MedPAC study on low-volume, isolated rural health care providers.

TITLE III—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

- Sec. 301. Revision of acute care hospital payment update for 2001.
- Sec. 302. Additional modification in transition for indirect medical education (IME) percentage adjustment.
- Sec. 303. Decrease in reductions for disproportionate share hospital (DSH) payments.

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- Sec. 304. Wage index improvements.
- Sec. 305. Payment for inpatient services of rehabilitation hospitals.
- Sec. 306. Payment for inpatient services of psychiatric hospitals.
- Sec. 307. Payment for inpatient services of long-term care hospitals.

Subtitle B—Adjustments to PPS Payments for Skilled Nursing Facilities

- Sec. 311. Elimination of reduction in skilled nursing facility (SNF) market basket update in 2001.
- Sec. 312. Increase in nursing component of PPS Federal rate.
- Sec. 313. Application of SNF consolidated billing requirement limited to part A covered stays.
- Sec. 314. Adjustment of rehabilitation RUGs to correct anomaly in payment rates.
- Sec. 315. Establishment of process for geographic reclassification.

Subtitle C—Hospice Care

- Sec. 321. Full market basket increase for 2001.
- Sec. 322. Clarification of physician certification.
- Sec. 323. MedPAC report on access to, and use of, hospice benefit.

Subtitle D—Other Provisions

- Sec. 331. Relief from medicare part A late enrollment penalty for group buy-in for State and local retirees.
- Sec. 332. Posting of information on nursing facility staffing.

TITLE IV—PROVISIONS RELATING TO PART B

Subtitle A—Hospital Outpatient Services

- Sec. 401. Revision of hospital outpatient PPS payment update.
- Sec. 402. Clarifying process and standards for determining eligibility of devices for pass-through payments under hospital outpatient PPS.
- Sec. 403. Application of OPD PPS transitional corridor payments to certain hospitals that did not submit a 1996 cost report.
- Sec. 404. Application of rules for determining provider-based status for certain entities.
- Sec. 405. Treatment of children's hospitals under prospective payment system.
- Sec. 406. Inclusion of temperature monitored cryoablation in transitional pass-through for certain medical devices, drugs, and biologicals under OPD PPS.

Subtitle B—Provisions Relating to Physicians' Services

- Sec. 411. GAO studies relating to physicians' services.
- Sec. 412. Physician group practice demonstration.
- Sec. 413. Study on enrollment procedures for groups that retain independent contractor physicians.

Subtitle C—Other Services

- Sec. 421. 1-year extension of moratorium on therapy caps; report on standards for supervision of physical therapy assistants.
- Sec. 422. Update in renal dialysis composite rate.
- Sec. 423. Payment for ambulance services.
- Sec. 424. Ambulatory surgical centers.
- Sec. 425. Full update for durable medical equipment.
- Sec. 426. Full update for orthotics and prosthetics.
- Sec. 427. Establishment of special payment provisions and requirements for prosthetics and certain custom fabricated orthotic items.
- Sec. 428. Replacement of prosthetic devices and parts.

- Sec. 429. Revised part B payment for drugs and biologicals and related services.
- Sec. 430. Contrast enhanced diagnostic procedures under hospital prospective payment system.
- Sec. 431. Qualifications for community mental health centers.
- Sec. 432. Modification of medicare billing requirements for certain Indian providers.
- Sec. 433. GAO study on coverage of surgical first assisting services of certified registered nurse first assistants.
- Sec. 434. MedPAC study and report on medicare reimbursement for services provided by certain providers.
- Sec. 435. MedPAC study and report on medicare coverage of services provided by certain nonphysician providers.
- Sec. 436. GAO study and report on the costs of emergency and medical transportation services.
- Sec. 437. GAO studies and reports on medicare payments.
- Sec. 438. MedPAC study on access to outpatient pain management services.

TITLE V—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

- Sec. 501. 1-year additional delay in application of 15 percent reduction on payment limits for home health services.
- Sec. 502. Restoration of full home health market basket update for home health services for fiscal year 2001.
- Sec. 503. Temporary two-month extension of periodic interim payments.
- Sec. 504. Use of telehealth in delivery of home health services.
- Sec. 505. Study on costs to home health agencies of purchasing nonroutine medical supplies.
- Sec. 506. Treatment of branch offices; GAO study on supervision of home health care provided in isolated rural areas.
- Sec. 507. Clarification of the homebound definition under the medicare home health benefit.

Subtitle B—Direct Graduate Medical Education

- Sec. 511. Increase in floor for direct graduate medical education payments.
- Sec. 512. Change in distribution formula for Medicare+ Choice-related nursing and allied health education costs.

Subtitle C—Changes in Medicare Coverage and Appeals Process

- Sec. 521. Revisions to medicare appeals process.
- Sec. 522. Revisions to medicare coverage process.

Subtitle D—Improving Access to New Technologies

- Sec. 531. Reimbursement improvements for new clinical laboratory tests and durable medical equipment.
- Sec. 532. Retention of HCPCS level III codes.
- Sec. 533. Recognition of new medical technologies under inpatient hospital PPS.

Subtitle E—Other Provisions

- Sec. 541. Increase in reimbursement for bad debt.
- Sec. 542. Treatment of certain physician pathology services under medicare.
- Sec. 543. Extension of advisory opinion authority.
- Sec. 544. Change in annual MedPAC reporting.
- Sec. 545. Development of patient assessment instruments.

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Sec. 546. GAO report on impact of the Emergency Medical Treatment and Active Labor Act (EMTALA) on hospital emergency departments.

TITLE VI—PROVISIONS RELATING TO PART C
(MEDICARE+CHOICE PROGRAM) AND OTHER MEDICARE MAN-
AGED CARE PROVISIONS

Subtitle A—Medicare+ Choice Payment Reforms

- Sec. 601. Increase in minimum payment amount.
- Sec. 602. Increase in minimum percentage increase.
- Sec. 603. 10-year phase-in of risk adjustment.
- Sec. 604. Transition to revised Medicare+ Choice payment rates.
- Sec. 605. Revision of payment rates for ESRD patients enrolled in Medicare+ Choice plans.
- Sec. 606. Permitting premium reductions as additional benefits under Medicare+ Choice plans.
- Sec. 607. Full implementation of risk adjustment for congestive heart failure enrollees for 2001.
- Sec. 608. Expansion of application of Medicare+ Choice new entry bonus.
- Sec. 609. Report on inclusion of certain costs of the Department of Veterans Affairs and military facility services in calculating Medicare+ Choice payment rates.

Subtitle B—Other Medicare+ Choice Reforms

- Sec. 611. Payment of additional amounts for new benefits covered during a contract term.
- Sec. 612. Restriction on implementation of significant new regulatory requirements mid-year.
- Sec. 613. Timely approval of marketing material that follows model marketing language.
- Sec. 614. Avoiding duplicative regulation.
- Sec. 615. Election of uniform local coverage policy for Medicare+ Choice plan covering multiple localities.
- Sec. 616. Eliminating health disparities in Medicare+ Choice program.
- Sec. 617. Medicare+ Choice program compatibility with employer or union group health plans.
- Sec. 618. Special medigap enrollment antidiscrimination provision for certain beneficiaries.
- Sec. 619. Restoring effective date of elections and changes of elections of Medicare+ Choice plans.
- Sec. 620. Permitting ESRD beneficiaries to enroll in another Medicare+ Choice plan if the plan in which they are enrolled is terminated.
- Sec. 621. Providing choice for skilled nursing facility services under the Medicare+ Choice program.
- Sec. 622. Providing for accountability of Medicare+ Choice plans.

Subtitle C—Other Managed Care Reforms

- Sec. 631. 1-year extension of social health maintenance organization (SHMO) demonstration project.
- Sec. 632. Revised terms and conditions for extension of medicare community nursing organization (CNO) demonstration project.
- Sec. 633. Extension of medicare municipal health services demonstration projects.
- Sec. 634. Service area expansion for medicare cost contracts during transition period.

TITLE VII—MEDICAID

- Sec. 701. DSH payments.
- Sec. 702. New prospective payment system for Federally-qualified health centers and rural health clinics.
- Sec. 703. Streamlined approval of continued State-wide section 1115 medicaid waivers.
- Sec. 704. Medicaid county-organized health systems.
- Sec. 705. Deadline for issuance of final regulation relating to medicaid upper payment limits.
- Sec. 706. Alaska FMAP.

TITLE VIII—STATE CHILDREN’S HEALTH INSURANCE PROGRAM

- Sec. 801. Special rule for redistribution and availability of unused fiscal year 1998 and 1999 SCHIP allotments.
- Sec. 802. Authority to pay medicaid expansion SCHIP costs from title XXI appropriation.

TITLE IX—OTHER PROVISIONS

Subtitle A—PACE Program

- Sec. 901. Extension of transition for current waivers.
- Sec. 902. Continuing of certain operating arrangements permitted.
- Sec. 903. Flexibility in exercising waiver authority.

Subtitle B—Outreach to Eligible Low-Income Medicare Beneficiaries

- Sec. 911. Outreach on availability of medicare cost-sharing assistance to eligible low-income medicare beneficiaries.

Subtitle C—Maternal and Child Health Block Grant

- Sec. 921. Increase in authorization of appropriations for the maternal and child health services block grant.

Subtitle D—Diabetes

- Sec. 931. Increase in appropriations for special diabetes programs for type I diabetes and Indians.
- Sec. 932. Appropriations for Ricky Ray Hemophilia Relief Fund.

TITLE I—MEDICARE BENEFICIARY IMPROVEMENTS

Subtitle A—Improved Preventive Benefits

SEC. 101. COVERAGE OF BIENNIAL SCREENING PAP SMEAR AND PELVIC EXAMS.

(a) IN GENERAL.—

(1) BIENNIAL SCREENING PAP SMEAR.—Section 1861(nn)(1) (42 U.S.C. 1395x(nn)(1)) is amended by striking “3 years” and inserting “2 years”.

(2) BIENNIAL SCREENING PELVIC EXAM.—Section 1861(nn)(2) (42 U.S.C. 1395x(nn)(2)) is amended by striking “3 years” and inserting “2 years”.

1 (b) EFFECTIVE DATE.—The amendments made by sub-
2 section (a) apply to items and services furnished on or after
3 July 1, 2001.

4 **SEC. 102. COVERAGE OF SCREENING FOR GLAUCOMA.**

5 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.
6 1395x(s)(2)) is amended—

7 (1) by striking “and” at the end of subparagraph (S);

8 (2) by inserting “and” at the end of subparagraph
9 (T); and

10 (3) by adding at the end the following:

11 “(U) screening for glaucoma (as defined in subsection
12 (uu)) for individuals determined to be at high risk for glau-
13 coma, individuals with a family history of glaucoma and in-
14 dividuals with diabetes;”.

15 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.
16 1395x) is amended by adding at the end the following new sub-
17 section:

18 “Screening for Glaucoma

19 “(uu) The term ‘screening for glaucoma’ means a dilated
20 eye examination with an intraocular pressure measurement,
21 and a direct ophthalmoscopy or a slit-lamp biomicroscopic ex-
22 amination for the early detection of glaucoma which is fur-
23 nished by or under the direct supervision of an optometrist or
24 ophthalmologist who is legally authorized to furnish such serv-
25 ices under State law (or the State regulatory mechanism pro-
26 vided by State law) of the State in which the services are fur-
27 nished, as would otherwise be covered if furnished by a physi-
28 cian or as an incident to a physician’s professional service, if
29 the individual involved has not had such an examination in the
30 preceding year.”.

31 (c) CONFORMING AMENDMENT.—Section 1862(a)(1)(F)
32 (42 U.S.C. 1395y(a)(1)(F)) is amended—

33 (1) by striking “and;” and

34 (2) by adding at the end the following: “and, in the
35 case of screening for glaucoma, which is performed more
36 frequently than is provided under section 1861(uu),”.

1 (d) EFFECTIVE DATE.—The amendments made by this
2 section shall apply to services furnished on or after January 1,
3 2002.

4 **SEC. 103. COVERAGE OF SCREENING COLONOSCOPY**
5 **FOR AVERAGE RISK INDIVIDUALS.**

6 (a) IN GENERAL.—Section 1861(pp) (42 U.S.C.
7 1395x(pp)) is amended—

8 (1) in paragraph (1)(C), by striking “In the case of
9 an individual at high risk for colorectal cancer, screening
10 colonoscopy” and inserting “Screening colonoscopy”; and

11 (2) in paragraph (2), by striking “In paragraph
12 (1)(C), an” and inserting “An”.

13 (b) FREQUENCY LIMITS FOR SCREENING
14 COLONOSCOPY.—Section 1834(d) (42 U.S.C. 1395m(d)) is
15 amended—

16 (1) in paragraph (2)(E)(ii), by inserting before the pe-
17 riod at the end the following: “or, in the case of an indi-
18 vidual who is not at high risk for colorectal cancer, if the
19 procedure is performed within the 119 months after a pre-
20 vious screening colonoscopy”;

21 (2) in paragraph (3)—

22 (A) in the heading by striking “FOR INDIVIDUALS
23 AT HIGH RISK FOR COLORECTAL CANCER”;

24 (B) in subparagraph (A), by striking “for individ-
25 uals at high risk for colorectal cancer (as defined in
26 section 1861(pp)(2))”;

27 (C) in subparagraph (E), by inserting before the
28 period at the end the following: “or for other individ-
29 uals if the procedure is performed within the 119
30 months after a previous screening colonoscopy or within
31 47 months after a previous screening flexible
32 sigmoidoscopy”.

33 (c) EFFECTIVE DATE.—The amendments made by this
34 section apply to colorectal cancer screening services provided on
35 or after July 1, 2001.

1 **SEC. 104. MODERNIZATION OF SCREENING MAMMOG-**
2 **RAPHY BENEFIT.**

3 (a) INCLUSION IN PHYSICIAN FEE SCHEDULE.—Section
4 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)) is amended by inserting
5 “(13),” after “(4),”.

6 (b) CONFORMING AMENDMENT.—Section 1834(c) (42
7 U.S.C. 1395m(c)) is amended to read as follows:

8 “(c) PAYMENT AND STANDARDS FOR SCREENING MAM-
9 MOGRAPHY.—

10 “(1) IN GENERAL.—With respect to expenses incurred
11 for screening mammography (as defined in section
12 1861(jj)), payment may be made only—

13 “(A) for screening mammography conducted con-
14 sistent with the frequency permitted under paragraph
15 (2); and

16 “(B) if the screening mammography is conducted
17 by a facility that has a certificate (or provisional certifi-
18 cate) issued under section 354 of the Public Health
19 Service Act.

20 “(2) FREQUENCY COVERED.—

21 “(A) IN GENERAL.—Subject to revision by the
22 Secretary under subparagraph (B)—

23 “(i) no payment may be made under this part
24 for screening mammography performed on a
25 woman under 35 years of age;

26 “(ii) payment may be made under this part for
27 only one screening mammography performed on a
28 woman over 34 years of age, but under 40 years
29 of age; and

30 “(iii) in the case of a woman over 39 years of
31 age, payment may not be made under this part for
32 screening mammography performed within 11
33 months following the month in which a previous
34 screening mammography was performed.

35 “(B) REVISION OF FREQUENCY.—

36 “(i) REVIEW.—The Secretary, in consultation
37 with the Director of the National Cancer Institute,

1 shall review periodically the appropriate frequency
2 for performing screening mammography, based on
3 age and such other factors as the Secretary believes
4 to be pertinent.

5 “(ii) REVISION OF FREQUENCY.—The Sec-
6 retary, taking into consideration the review made
7 under clause (i), may revise from time to time the
8 frequency with which screening mammography may
9 be paid for under this subsection.”.

10 (c) EFFECTIVE DATE.—The amendments made by sub-
11 sections (a) and (b) apply with respect to screening
12 mammographies furnished on or after January 1, 2002.

13 (d) PAYMENT FOR NEW TECHNOLOGIES.—

14 (1) TESTS FURNISHED IN 2001.—

15 (A) SCREENING.—For a screening mammography
16 (as defined in section 1861(jj) of the Social Security
17 Act (42 U.S.C. 1395(jj))) furnished during the period
18 beginning on April 1, 2001, and ending on December
19 31, 2001, that uses a new technology, payment for
20 such screening mammography shall be made as follows:

21 (i) In the case of a technology which directly
22 takes a digital image (without involving film) and
23 subsequently analyzes such resulting image with
24 software to identify possible problem areas, in an
25 amount equal to 150 percent of the amount of pay-
26 ment under section 1848 of such Act (42 U.S.C.
27 1395w-4) for a bilateral diagnostic mammography
28 (under HCPCS code 76091) for such year.

29 (ii) In the case of a technology which allows
30 conversion of a standard film mammogram into a
31 digital image and subsequently analyzes such re-
32 sulting image with software to identify possible
33 problem areas, in an amount equal to the limit that
34 would otherwise be applied under section
35 1834(c)(3) of such Act (42 U.S.C. 1395m(c)(3))
36 for 2001, increased by \$15.

1 (B) BILATERAL DIAGNOSTIC MAMMOGRAPHY.—
2 For a bilateral diagnostic mammography (under
3 HCPCS code 76091) furnished during the period be-
4 ginning on April 1, 2001, and ending on December 31,
5 2001, that uses a new technology described in subpara-
6 graph (A)(i), payment for such mammography shall be
7 the amount of payment provided for under such sub-
8 paragraph.

9 The Secretary of Health and Human Services may imple-
10 ment the provisions of this paragraph by program memo-
11 randum or otherwise.

12 (2) CONSIDERATION OF NEW HCPCS CODE FOR NEW
13 TECHNOLOGIES AFTER 2001.—The Secretary shall deter-
14 mine, for such screening mammographies performed after
15 2001, whether the assignment of a new HCPCS code is ap-
16 propriate for screening mammography that uses a new
17 technology. If the Secretary determines that a new code is
18 appropriate for such screening mammography, the Sec-
19 retary shall provide for such new code for such tests fur-
20 nished after 2001.

21 (3) NEW TECHNOLOGY DESCRIBED.—For purposes of
22 this subsection, a new technology with respect to a screen-
23 ing mammography is an advance in technology with respect
24 to the test or equipment that results in the following:

25 (A) A significant increase or decrease in the re-
26 sources used in the test or in the manufacture of the
27 equipment.

28 (B) A significant improvement in the performance
29 of the test or equipment.

30 (C) A significant advance in medical technology
31 that is expected to significantly improve the treatment
32 of medicare beneficiaries.

33 (4) HCPCS CODE DEFINED.—The term “HCPCS
34 code” means an alphanumeric code under the Health Care
35 Financing Administration Common Procedure Coding Sys-
36 tem (HCPCS).

1 **SEC. 105. COVERAGE OF MEDICAL NUTRITION THERAPY**
2 **SERVICES FOR BENEFICIARIES WITH DIABE-**
3 **TES OR A RENAL DISEASE.**

4 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.
5 1395x(s)(2)), as amended by section 102(a), is amended—

6 (1) in subparagraph (T), by striking “and” at the end;

7 (2) in subparagraph (U), by inserting “and” at the
8 end; and

9 (3) by adding at the end the following new subpara-
10 graph:

11 “(V) medical nutrition therapy services (as defined in
12 subsection (vv)(1)) in the case of a beneficiary with diabe-
13 tes or a renal disease who—

14 “(i) has not received diabetes outpatient self-man-
15 agement training services within a time period deter-
16 mined by the Secretary; and

17 “(ii) meets such other criteria determined by the
18 Secretary after consideration of protocols established by
19 dietitian or nutrition professional organizations;”.

20 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.
21 1395x), as amended by section 102(b), is amended by adding
22 at the end the following:

23 “Medical Nutrition Therapy Services; Registered Dietitian or
24 Nutrition Professional

25 “(vv)(1) The term ‘medical nutrition therapy services’
26 means nutritional diagnostic, therapy, and counseling services
27 for the purpose of disease management which are furnished by
28 a registered dietitian or nutrition professional (as defined in
29 paragraph (2)) pursuant to a referral by a physician (as de-
30 fined in subsection (r)(1)).

31 “(2) Subject to paragraph (3), the term ‘registered dieti-
32 tarian or nutrition professional’ means an individual who—

33 “(A) holds a baccalaureate or higher degree granted
34 by a regionally accredited college or university in the
35 United States (or an equivalent foreign degree) with com-
36 pletion of the academic requirements of a program in nutri-
37 tion or dietetics, as accredited by an appropriate national

1 accreditation organization recognized by the Secretary for
2 this purpose;

3 “(B) has completed at least 900 hours of supervised
4 dietetics practice under the supervision of a registered die-
5 titian or nutrition professional; and

6 “(C)(i) is licensed or certified as a dietitian or nutri-
7 tion professional by the State in which the services are per-
8 formed; or

9 “(ii) in the case of an individual in a State that does
10 not provide for such licensure or certification, meets such
11 other criteria as the Secretary establishes.

12 “(3) Subparagraphs (A) and (B) of paragraph (2) shall
13 not apply in the case of an individual who, as of the date of
14 the enactment of this subsection, is licensed or certified as a
15 dietitian or nutrition professional by the State in which medical
16 nutrition therapy services are performed.”.

17 (c) PAYMENT.—Section 1833(a)(1) (42 U.S.C.
18 1395l(a)(1)) is amended—

19 (1) by striking “and” before “(S)”; and

20 (2) by inserting before the semicolon at the end the
21 following: “, and (T) with respect to medical nutrition ther-
22 apy services (as defined in section 1861(vv)), the amount
23 paid shall be 80 percent of the lesser of the actual charge
24 for the services or 85 percent of the amount determined
25 under the fee schedule established under section 1848(b)
26 for the same services if furnished by a physician”.

27 (d) APPLICATION OF LIMITS ON BILLING.—Section
28 1842(b)(18)(C) (42 U.S.C. 1395u(b)(18)(C)) is amended by
29 adding at the end the following new clause:

30 “(vi) A registered dietitian or nutrition professional.”.

31 (e) EFFECTIVE DATE.—The amendments made by this
32 section apply to services furnished on or after January 1, 2002.

33 (f) STUDY.—Not later than July 1, 2003, the Secretary of
34 Health and Human Services shall submit to Congress a report
35 that contains recommendations with respect to the expansion to
36 other medicare beneficiary populations of the medical nutrition

1 therapy services benefit (furnished under the amendments
2 made by this section).

3 **Subtitle B—Other Beneficiary**
4 **Improvements**

5 **SEC. 111. ACCELERATION OF REDUCTION OF BENE-**
6 **FICIARY COPAYMENT FOR HOSPITAL OUT-**
7 **PATIENT DEPARTMENT SERVICES.**

8 (a) REDUCING THE UPPER LIMIT ON BENEFICIARY CO-
9 PAYMENT.—

10 (1) IN GENERAL.—Section 1833(t)(8)(C) (42 U.S.C.
11 1395l(t)(8)(C)) is amended to read as follows:

12 “(C) LIMITATION ON COPAYMENT AMOUNT.—

13 “(i) TO INPATIENT HOSPITAL DEDUCTIBLE
14 AMOUNT.—In no case shall the copayment amount
15 for a procedure performed in a year exceed the
16 amount of the inpatient hospital deductible estab-
17 lished under section 1813(b) for that year.

18 “(ii) TO SPECIFIED PERCENTAGE.—The Sec-
19 retary shall reduce the national unadjusted copy-
20 payment amount for a covered OPD service (or group
21 of such services) furnished in a year in a manner
22 so that the effective copayment rate (determined on
23 a national unadjusted basis) for that service in the
24 year does not exceed the following percentage:

25 “(I) For procedures performed in 2001,
26 60 percent.

27 “(II) For procedures performed in 2002 or
28 2003, 55 percent.

29 “(III) For procedures performed in 2004,
30 50 percent.

31 “(IV) For procedures performed in 2005,
32 45 percent.

33 “(V) For procedures performed in 2006
34 and thereafter, 40 percent.”.

35 (2) EFFECTIVE DATE.—The amendment made by
36 paragraph (1) applies with respect to services furnished on
37 or after January 1, 2001.

1 (b) CONSTRUCTION REGARDING LIMITING INCREASES IN
2 COST-SHARING.—Nothing in this Act or the Social Security
3 Act shall be construed as preventing a hospital from waiving
4 the amount of any coinsurance for outpatient hospital services
5 under the medicare program under title XVIII of the Social Se-
6 curity Act that may have been increased as a result of the im-
7 plementation of the prospective payment system under section
8 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)).

9 (c) GAO STUDY OF REDUCTION IN MEDIGAP PREMIUM
10 LEVELS RESULTING FROM REDUCTIONS IN COINSURANCE.—
11 The Comptroller General of the United States shall work, in
12 concert with the National Association of Insurance Commis-
13 sioners, to evaluate the extent to which the premium levels for
14 medicare supplemental policies reflect the reductions in coinsur-
15 ance resulting from the amendment made by subsection (a).
16 Not later than April 1, 2004, the Comptroller General shall
17 submit to Congress a report on such evaluation and the extent
18 to which the reductions in beneficiary coinsurance effected by
19 such amendment have resulted in actual savings to medicare
20 beneficiaries.

21 **SEC. 112. PRESERVATION OF COVERAGE OF DRUGS AND**
22 **BIOLOGICALS UNDER PART B OF THE MEDI-**
23 **CARE PROGRAM.**

24 (a) IN GENERAL.—Section 1861(s)(2) (42 U.S.C.
25 1395x(s)(2)) is amended, in each of subparagraphs (A) and
26 (B), by striking “(including drugs and biologicals which cannot,
27 as determined in accordance with regulations, be self-adminis-
28 tered)” and inserting “(including drugs and biologicals which
29 are not usually self-administered by the patient)”.

30 (b) EFFECTIVE DATE.—The amendment made by sub-
31 section (a) applies to drugs and biologicals administered on or
32 after the date of the enactment of this Act.

33 **SEC. 113. ELIMINATION OF TIME LIMITATION ON MEDI-**
34 **CARE BENEFITS FOR IMMUNOSUPPRESSIVE**
35 **DRUGS.**

36 (a) IN GENERAL.—Section 1861(s)(2)(J) (42 U.S.C.
37 1395x(s)(2)(J)) is amended by striking “, but only” and all
38 that follows up to the semicolon at the end.

1 (b) CONFORMING AMENDMENTS.—

2 (1) EXTENDED COVERAGE.—Section 1832 (42 U.S.C.
3 1395k) is amended—

4 (A) by striking subsection (b); and

5 (B) by redesignating subsection (c) as subsection
6 (b).

7 (2) PASS-THROUGH; REPORT.—Section 227 of BBRA
8 is amended by striking subsection (d).

9 (c) EFFECTIVE DATE.—The amendment made by sub-
10 section (a) shall apply to drugs furnished on or after the date
11 of the enactment of this Act.

12 **SEC. 114. IMPOSITION OF BILLING LIMITS ON PRE-**
13 **SCRIPTION DRUGS.**

14 (a) IN GENERAL.—Section 1842(o) (42 U.S.C. 1395u(o))
15 is amended by adding at the end the following new paragraph:

16 “(3)(A) Payment for a charge for any drug or biological
17 for which payment may be made under this part may be made
18 under this part only on an assignment-related basis.

19 “(B) The provisions of subsection (b)(18)(B) shall apply
20 to charges for such drugs or biologicals in the same manner as
21 they apply to services furnished by a practitioner described in
22 subsection (b)(18)(C).”.

23 (b) EFFECTIVE DATE.—The amendment made by sub-
24 section (a) shall apply to items furnished on or after January
25 1, 2001.

26 **Subtitle C—Demonstration Projects**
27 **and Studies**

28 **SEC. 121. DEMONSTRATION PROJECT FOR DISEASE**
29 **MANAGEMENT FOR SEVERELY CHRON-**
30 **ICALLY ILL MEDICARE BENEFICIARIES.**

31 (a) IN GENERAL.—The Secretary of Health and Human
32 Services shall conduct a demonstration project under this sec-
33 tion (in this section referred to as the “project”) to dem-
34 onstrate the impact on costs and health outcomes of applying
35 disease management to medicare beneficiaries with diagnosed,
36 advanced-stage congestive heart failure, diabetes, or coronary

18

1 heart disease. In no case may the number of participants in the
2 project exceed 30,000 at any time.

3 (b) VOLUNTARY PARTICIPATION.—

4 (1) ELIGIBILITY.—Medicare beneficiaries are eligible
5 to participate in the project only if—

6 (A) they meet specific medical criteria dem-
7 onstrating the appropriate diagnosis and the advanced
8 nature of their disease;

9 (B) their physicians approve of participation in the
10 project; and

11 (C) they are not enrolled in a Medicare+ Choice
12 plan.

13 (2) BENEFITS.—A beneficiary who is enrolled in the
14 project shall be eligible—

15 (A) for disease management services related to
16 their chronic health condition; and

17 (B) for payment for all costs for prescription
18 drugs without regard to whether or not they relate to
19 the chronic health condition, except that the project
20 may provide for modest cost-sharing with respect to
21 prescription drug coverage.

22 (c) CONTRACTS WITH DISEASE MANAGEMENT ORGANIZA-
23 TIONS.—

24 (1) IN GENERAL.—The Secretary of Health and
25 Human Services shall carry out the project through con-
26 tracts with up to three disease management organizations.
27 The Secretary shall not enter into such a contract with an
28 organization unless the organization demonstrates that it
29 can produce improved health outcomes and reduce aggre-
30 gate medicare expenditures consistent with paragraph (2).

31 (2) CONTRACT PROVISIONS.—Under such contracts—

32 (A) such an organization shall be required to pro-
33 vide for prescription drug coverage described in sub-
34 section (b)(2)(B);

35 (B) such an organization shall be paid a fee nego-
36 tiated and established by the Secretary in a manner so
37 that (taking into account savings in expenditures under

1 parts A and B of the medicare program under title
2 XVIII of the Social Security Act) there will be a net
3 reduction in expenditures under the medicare program
4 as a result of the project; and

5 (C) such an organization shall guarantee, through
6 an appropriate arrangement with a reinsurance com-
7 pany or otherwise, the net reduction in expenditures
8 described in subparagraph (B).

9 (3) PAYMENTS.—Payments to such organizations shall
10 be made in appropriate proportion from the Trust Funds
11 established under title XVIII of the Social Security Act.

12 (d) APPLICATION OF MEDIGAP PROTECTIONS TO DEM-
13 ONSTRATION PROJECT ENROLLEES.—(1) Subject to paragraph
14 (2), the provisions of section 1882(s)(3) (other than clauses (i)
15 through (iv) of subparagraph (B)) and 1882(s)(4) of the Social
16 Security Act shall apply to enrollment (and termination of en-
17 rollment) in the demonstration project under this section, in
18 the same manner as they apply to enrollment (and termination
19 of enrollment) with a Medicare+ Choice organization in a
20 Medicare+ Choice plan.

21 (2) In applying paragraph (1)—

22 (A) any reference in clause (v) or (vi) of section
23 1882(s)(3)(B) of such Act to 12 months is deemed a ref-
24 erence to the period of the demonstration project; and

25 (B) the notification required under section
26 1882(s)(3)(D) of such Act shall be provided in a manner
27 specified by the Secretary of Health and Human Services.

28 (e) DURATION.—The project shall last for not longer than
29 3 years.

30 (f) WAIVER.—The Secretary of Health and Human Serv-
31 ices shall waive such provisions of title XVIII of the Social Se-
32 curity Act as may be necessary to provide for payment for serv-
33 ices under the project in accordance with subsection (c)(3).

34 (g) REPORT.—The Secretary of Health and Human Serv-
35 ices shall submit to Congress an interim report on the project
36 not later than 2 years after the date it is first implemented and
37 a final report on the project not later than 6 months after the

1 date of its completion. Such reports shall include information
2 on the impact of the project on costs and health outcomes and
3 recommendations on the cost-effectiveness of extending or ex-
4 panding the project.

5 **SEC. 122. CANCER PREVENTION AND TREATMENT DEM-**
6 **ONSTRATION FOR ETHNIC AND RACIAL MI-**
7 **NORITIES.**

8 (a) DEMONSTRATION.—

9 (1) IN GENERAL.—The Secretary of Health and
10 Human Services (in this section referred to as the “Sec-
11 retary”) shall conduct demonstration projects (in this sec-
12 tion referred to as “demonstration projects”) for the pur-
13 pose of developing models and evaluating methods that—

14 (A) improve the quality of items and services pro-
15 vided to target individuals in order to facilitate reduced
16 disparities in early detection and treatment of cancer;

17 (B) improve clinical outcomes, satisfaction, quality
18 of life, and appropriate use of medicare-covered services
19 and referral patterns among those target individuals
20 with cancer;

21 (C) eliminate disparities in the rate of preventive
22 cancer screening measures, such as pap smears and
23 prostate cancer screenings, among target individuals;
24 and

25 (D) promote collaboration with community-based
26 organizations to ensure cultural competency of health
27 care professionals and linguistic access for persons with
28 limited English proficiency.

29 (2) TARGET INDIVIDUAL DEFINED.—In this section,
30 the term “target individual” means an individual of a racial
31 and ethnic minority group, as defined by section 1707 of
32 the Public Health Service Act, who is entitled to benefits
33 under part A, and enrolled under part B, of title XVIII of
34 the Social Security Act.

35 (b) PROGRAM DESIGN.—

36 (1) INITIAL DESIGN.—Not later than 1 year after the
37 date of the enactment of this Act, the Secretary shall evalu-

1 ate best practices in the private sector, community pro-
2 grams, and academic research of methods that reduce dis-
3 parities among individuals of racial and ethnic minority
4 groups in the prevention and treatment of cancer and shall
5 design the demonstration projects based on such evalua-
6 tion.

7 (2) NUMBER AND PROJECT AREAS.—Not later than 2
8 years after the date of the enactment of this Act, the Sec-
9 retary shall implement at least 9 demonstration projects,
10 including the following:

11 (A) 2 projects for each of the 4 major racial and
12 ethnic minority groups (American Indians (including
13 Alaska Natives, Eskimos, and Aleuts); Asian Ameri-
14 cans and Pacific Islanders; Blacks; and Hispanics. The
15 2 projects must target different ethnic subpopulations.

16 (B) 1 project within the Pacific Islands.

17 (C) At least 1 project each in a rural area and
18 inner-city area.

19 (3) EXPANSION OF PROJECTS; IMPLEMENTATION OF
20 DEMONSTRATION PROJECT RESULTS.—If the initial report
21 under subsection (c) contains an evaluation that dem-
22 onstration projects—

23 (A) reduce expenditures under the medicare pro-
24 gram under title XVIII of the Social Security Act; or

25 (B) do not increase expenditures under the medi-
26 care program and reduce racial and ethnic health dis-
27 parities in the quality of health care services provided
28 to target individuals and increase satisfaction of bene-
29 ficiaries and health care providers;

30 the Secretary shall continue the existing demonstration
31 projects and may expand the number of demonstration
32 projects.

33 (c) REPORT TO CONGRESS.—

34 (1) IN GENERAL.—Not later than 2 years after the
35 date the Secretary implements the initial demonstration
36 projects, and biannually thereafter, the Secretary shall sub-

1 mit to Congress a report regarding the demonstration
2 projects.

3 (2) CONTENTS OF REPORT.—Each report under para-
4 graph (1) shall include the following:

5 (A) A description of the demonstration projects.

6 (B) An evaluation of—

7 (i) the cost-effectiveness of the demonstration
8 projects;

9 (ii) the quality of the health care services pro-
10 vided to target individuals under the demonstration
11 projects; and

12 (iii) beneficiary and health care provider satis-
13 faction under the demonstration projects.

14 (C) Any other information regarding the dem-
15 onstration projects that the Secretary determines to be
16 appropriate.

17 (d) WAIVER AUTHORITY.—The Secretary shall waive com-
18 pliance with the requirements of title XVIII of the Social Secu-
19 rity Act to such extent and for such period as the Secretary
20 determines is necessary to conduct demonstration projects.

21 (e) FUNDING.—

22 (1) DEMONSTRATION PROJECTS.—

23 (A) STATE PROJECTS.—Except as provided in sub-
24 paragraph (B), the Secretary shall provide for the
25 transfer from the Federal Hospital Insurance Trust
26 Fund and the Federal Supplementary Insurance Trust
27 Fund under title XVIII of the Social Security Act, in
28 such proportions as the Secretary determines to be ap-
29 propriate, of such funds as are necessary for the costs
30 of carrying out the demonstration projects.

31 (B) TERRITORY PROJECTS.—In the case of a dem-
32 onstration project described in subsection (b)(2)(B),
33 amounts shall be available only as provided in any Fed-
34 eral law making appropriations for the territories.

35 (2) LIMITATION.—In conducting demonstration
36 projects, the Secretary shall ensure that the aggregate pay-
37 ments made by the Secretary do not exceed the sum of the

1 amount which the Secretary would have paid under the
2 program for the prevention and treatment of cancer if the
3 demonstration projects were not implemented, plus
4 \$25,000,000.

5 **SEC. 123. STUDY ON MEDICARE COVERAGE OF ROUTINE**
6 **THYROID SCREENING.**

7 (a) STUDY.—The Secretary of Health and Human Serv-
8 ices shall request the National Academy of Sciences, and as ap-
9 propriate in conjunction with the United States Preventive
10 Services Task Force, to conduct a study on the addition of cov-
11 erage of routine thyroid screening using a thyroid stimulating
12 hormone test as a preventive benefit provided to medicare bene-
13 ficiaries under title XVIII of the Social Security Act for some
14 or all medicare beneficiaries. In conducting the study, the
15 Academy shall consider the short-term and long-term benefits,
16 and costs to the medicare program, of such addition.

17 (b) REPORT.—Not later than 2 years after the date of the
18 enactment of this Act, the Secretary of Health and Human
19 Services shall submit a report on the findings of the study con-
20 ducted under subsection (a) to the Committee on Ways and
21 Means and the Committee on Commerce of the House of Rep-
22 resentatives and the Committee on Finance of the Senate.

23 **SEC. 124. MEDPAC STUDY ON CONSUMER COALITIONS.**

24 (a) STUDY.—The Medicare Payment Advisory Commission
25 shall conduct a study that examines the use of consumer coali-
26 tions in the marketing of Medicare+ Choice plans under the
27 medicare program under title XVIII of the Social Security Act.
28 The study shall examine—

29 (1) the potential for increased efficiency in the medi-
30 care program through greater beneficiary knowledge of
31 their health care options, decreased marketing costs of
32 Medicare+ Choice organizations, and creation of a group
33 market;

34 (2) the implications of Medicare+ Choice plans and
35 medicare supplemental policies (under section 1882 of the
36 Social Security Act (42 U.S.C. 1395ss)) offering medicare
37 beneficiaries in the same geographic location different bene-

1 fits and premiums based on their affiliation with a con-
2 sumer coalition;

3 (3) how coalitions should be governed, how they should
4 be accountable to the Secretary of Health and Human
5 Services, and how potential conflicts of interest in the ac-
6 tivities of consumer coalitions should be avoided; and

7 (4) how such coalitions should be funded.

8 (b) REPORT.—Not later than 1 year after the date of the
9 enactment of this Act, the Commission shall submit to Con-
10 gress a report on the study conducted under subsection (a).
11 The report shall include a recommendation on whether and how
12 a demonstration project might be conducted for the operation
13 of consumer coalitions under the medicare program.

14 (c) CONSUMER COALITION DEFINED.—For purposes of
15 this section, the term “consumer coalition” means a nonprofit,
16 community-based group of organizations that—

17 (1) provides information to medicare beneficiaries
18 about their health care options under the medicare pro-
19 gram; and

20 (2) negotiates benefits and premiums for medicare
21 beneficiaries who are members or otherwise affiliated with
22 the group of organizations with Medicare+ Choice organiza-
23 tions offering Medicare+ Choice plans, issuers of medicare
24 supplemental policies, issuers of long-term care coverage,
25 and pharmacy benefit managers.

26 **SEC. 125. STUDY ON LIMITATION ON STATE PAYMENT**
27 **FOR MEDICARE COST-SHARING AFFECTING**
28 **ACCESS TO SERVICES FOR QUALIFIED MEDI-**
29 **CARE BENEFICIARIES.**

30 (a) IN GENERAL.—The Secretary of Health and Human
31 Services shall conduct a study to determine if access to certain
32 services (including mental health services) for qualified medi-
33 care beneficiaries has been affected by limitations on a State’s
34 payment for medicare cost-sharing for such beneficiaries under
35 section 1902(n) of the Social Security Act (42 U.S.C.
36 1396a(n)). As part of such study, the Secretary shall analyze

1 the effect of such payment limitation on providers who serve a
2 disproportionate share of such beneficiaries.

3 (b) REPORT.—Not later than 1 year after the date of the
4 enactment of this Act, the Secretary shall submit to Congress
5 a report on the study under subsection (a). The report shall in-
6 clude recommendations regarding any changes that should be
7 made to the State payment limits under section 1902(n) for
8 qualified medicare beneficiaries to ensure appropriate access to
9 services.

10 **SEC. 126. INSTITUTE OF MEDICINE STUDY ON WAIVER**
11 **OF 24-MONTH WAITING PERIOD FOR MEDI-**
12 **CARE DISABILITY ELIGIBILITY FOR**
13 **AMYOTROPHIC LATERAL SCLEROSIS (ALS)**
14 **AND OTHER DEVASTATING DISEASES.**

15 (a) STUDY.—The Secretary of Health and Human Serv-
16 ices shall enter into a contract with the Institute of Medicine
17 to conduct a study that examines the appropriateness of
18 waiving the 24-month waiting period for eligibility for benefits
19 under the medicare program under title XVIII of the Social Se-
20 curity Act applicable under section 226(b) of such Act (42
21 U.S.C. 426(b)) for individuals with a devastating disease. For
22 purposes of this section, the term “devastating disease” means
23 amyotrophic lateral sclerosis (ALS) and includes any other dis-
24 ease that is as rapidly debilitating as ALS.

25 (b) REPORT.—The contract shall provide for the submis-
26 sion to Congress and the Secretary of a report on the study
27 conducted under subsection (a) by not later than 18 months
28 after the date of the enactment of this Act.

29 **SEC. 127. STUDIES ON PREVENTIVE INTERVENTIONS IN**
30 **PRIMARY CARE FOR OLDER AMERICANS.**

31 (a) STUDIES.—The Secretary of Health and Human Serv-
32 ices, acting through the United States Preventive Services Task
33 Force, shall conduct a series of studies designed to identify pre-
34 ventive interventions that can be delivered in the primary care
35 setting and that are most valuable to older Americans.

36 (b) MISSION STATEMENT.—The mission statement of the
37 United States Preventive Services Task Force is amended to

1 include the evaluation of services that are of particular rel-
2 evance to older Americans.

3 (c) REPORT.—Not later than 1 year after the date of the
4 enactment of this Act, and annually thereafter, the Secretary
5 of Health and Human Services shall submit to Congress a re-
6 port on the conclusions of the studies conducted under sub-
7 section (a), together with recommendations for such legislation
8 and administrative actions as the Secretary considers appro-
9 priate.

10 **SEC. 128. MEDPAC STUDY AND REPORT ON MEDICARE**
11 **COVERAGE OF CARDIAC AND PULMONARY**
12 **REHABILITATION THERAPY SERVICES.**

13 (a) STUDY.—

14 (1) IN GENERAL.—The Medicare Payment Advisory
15 Commission shall conduct a study on coverage of cardiac
16 and pulmonary rehabilitation therapy services under the
17 medicare program under title XVIII of the Social Security
18 Act.

19 (2) FOCUS.—In conducting the study under paragraph
20 (1), the Commission shall focus on the appropriate—

21 (A) qualifying diagnoses required for coverage of
22 cardiac and pulmonary rehabilitation therapy services;

23 (B) level of physician direct involvement and su-
24 pervision in furnishing such services; and

25 (C) level of reimbursement for such services.

26 (b) REPORT.—Not later than 18 months after the date of
27 the enactment of this Act, the Commission shall submit to Con-
28 gress a report on the study conducted under subsection (a) to-
29 gether with such recommendations for legislation and adminis-
30 trative action as the Commission determines appropriate.

1 **TITLE II—RURAL HEALTH CARE**
2 **IMPROVEMENTS**
3 **Subtitle A—Critical Access Hospital**
4 **Provisions**

5 **SEC. 201. CLARIFICATION OF NO BENEFICIARY COST-**
6 **SHARING FOR CLINICAL DIAGNOSTIC LAB-**
7 **ORATORY TESTS FURNISHED BY CRITICAL**
8 **ACCESS HOSPITALS.**

9 (a) **PAYMENT CLARIFICATION.**—Section 1834(g) (42
10 U.S.C. 1395m(g)) is amended by adding at the end the fol-
11 lowing new paragraph:

12 “(4) **NO BENEFICIARY COST-SHARING FOR CLINICAL**
13 **DIAGNOSTIC LABORATORY SERVICES.**—No coinsurance, de-
14 ductible, copayment, or other cost-sharing otherwise appli-
15 cable under this part shall apply with respect to clinical di-
16 agnostic laboratory services furnished as an outpatient crit-
17 ical access hospital service. Nothing in this title shall be
18 construed as providing for payment for clinical diagnostic
19 laboratory services furnished as part of outpatient critical
20 access hospital services, other than on the basis described
21 in this subsection.”.

22 (b) **TECHNICAL AND CONFORMING AMENDMENTS.**—

23 (1) Paragraphs (1)(D)(i) and (2)(D)(i) of section
24 1833(a) (42 U.S.C. 1395l(a)) are each amended by striking
25 “or which are furnished on an outpatient basis by a critical
26 access hospital”.

27 (2) Section 403(d)(2) of BBRA (113 Stat. 1501A-
28 371) is amended by striking “The amendment made by
29 subsection (a) shall apply” and inserting “Paragraphs (1)
30 through (3) of section 1834(g) of the Social Security Act
31 (as amended by paragraph (1)) apply”.

32 (c) **EFFECTIVE DATES.**—The amendment made—

33 (1) by subsection (a) applies to services furnished on
34 or after the date of the enactment of BBRA;

35 (2) by subsection (b)(1) applies as if included in the
36 enactment of section 403(e)(1) of BBRA (113 Stat.
37 1501A-371); and

1 (3) by subsection (b)(2) applies as if included in the
2 enactment of section 403(d)(2) of BBRA (113 Stat.
3 1501A-371).

4 **SEC. 202. ASSISTANCE WITH FEE SCHEDULE PAYMENT**
5 **FOR PROFESSIONAL SERVICES UNDER ALL-**
6 **INCLUSIVE RATE.**

7 (a) IN GENERAL.—Section 1834(g)(2)(B) (42 U.S.C.
8 1395m(g)(2)(B)) is amended by inserting “115 percent of” be-
9 fore “such amounts”.

10 (b) EFFECTIVE DATE.—The amendment made by sub-
11 section (a) applies with respect to items and services furnished
12 on or after April 1, 2001.

13 **SEC. 203. EXEMPTION OF CRITICAL ACCESS HOSPITAL**
14 **SWING BEDS FROM SNF PPS.**

15 (a) IN GENERAL.—Section 1888(e)(7) (42 U.S.C.
16 1395yy(e)(7)) is amended—

17 (1) in the heading, by striking “TRANSITION FOR” and
18 inserting “TREATMENT OF”;

19 (2) in subparagraph (A), by striking “IN GENERAL.—
20 The” and inserting “TRANSITION.—Subject to subpara-
21 graph (C), the”;

22 (3) in subparagraph (A), by inserting “(other than
23 critical access hospitals)” after “facilities described in sub-
24 paragraph (B)”;

25 (4) in subparagraph (B), by striking “, for which pay-
26 ment” and all that follows before the period; and

27 (5) by adding at the end the following new subpara-
28 graph:

29 “(C) EXEMPTION FROM PPS OF SWING-BED SERV-
30 ICES FURNISHED IN CRITICAL ACCESS HOSPITALS.—
31 The prospective payment system established under this
32 subsection shall not apply to services furnished by a
33 critical access hospital pursuant to an agreement under
34 section 1883.”.

35 (b) PAYMENT ON A REASONABLE COST BASIS FOR SWING
36 BED SERVICES FURNISHED BY CRITICAL ACCESS HOS-
37 PITALS.—Section 1883(a) (42 U.S.C. 1395tt(a)) is amended—

1 (1) in paragraph (2)(A), by inserting “(other than a
2 critical access hospital)” after “any hospital”; and

3 (2) by adding at the end the following new paragraph:
4 “(3) Notwithstanding any other provision of this title, a
5 critical access hospital shall be paid for covered skilled nursing
6 facility services furnished under an agreement entered into
7 under this section on the basis of the reasonable costs of such
8 services (as determined under section 1861(v)).”.

9 (c) EFFECTIVE DATE.—The amendments made by this
10 section shall apply to cost reporting periods beginning on or
11 after the date of the enactment of this Act.

12 **SEC. 204. PAYMENT IN CRITICAL ACCESS HOSPITALS**
13 **FOR EMERGENCY ROOM ON-CALL PHYSI-**
14 **CIANS.**

15 (a) IN GENERAL.—Section 1834(g) (42 U.S.C.
16 1395m(g)), as amended by section 201(a), is further amended
17 by adding at the end the following new paragraph:

18 “(5) COVERAGE OF COSTS FOR EMERGENCY ROOM ON-
19 CALL PHYSICIANS.—In determining the reasonable costs of
20 outpatient critical access hospital services under para-
21 graphs (1) and (2)(A), the Secretary shall recognize as al-
22 lowable costs, amounts (as defined by the Secretary) for
23 reasonable compensation and related costs for emergency
24 room physicians who are on-call (as defined by the Sec-
25 retary) but who are not present on the premises of the crit-
26 ical access hospital involved, and are not otherwise fur-
27 nishing physicians’ services and are not on-call at any other
28 provider or facility.”.

29 (b) EFFECTIVE DATE.—The amendment made by sub-
30 section (a) applies to cost reporting periods beginning on or
31 after October 1, 2001.

32 **SEC. 205. TREATMENT OF AMBULANCE SERVICES FUR-**
33 **NISHED BY CERTAIN CRITICAL ACCESS HOS-**
34 **PITALS.**

35 (a) IN GENERAL.—Section 1834(l) (42 U.S.C. 1395m(l))
36 is amended by adding at the end the following new paragraph:

37 “(8) SERVICES FURNISHED BY CRITICAL ACCESS HOS-
38 PITALS.—Notwithstanding any other provision of this sub-

30

1 section, the Secretary shall pay the reasonable costs in-
2 curred in furnishing ambulance services if such services are
3 furnished—

4 “(A) by a critical access hospital (as defined in
5 section 1861(mm)(1)), or

6 “(B) by an entity that is owned and operated by
7 a critical access hospital,

8 but only if the critical access hospital or entity is the only
9 provider or supplier of ambulance services that is located
10 within a 35-mile drive of such critical access hospital.”.

11 (b) CONFORMING AMENDMENT.—Section 1833(a)(1)(R)
12 (42 U.S.C. 1395l(a)(1)(R)) is amended—

13 (1) by striking “ambulance service,” and inserting
14 “ambulance services, (i)”; and

15 (2) by inserting before the comma at the end the fol-
16 lowing: “and (ii) with respect to ambulance services de-
17 scribed in section 1834(l)(8), the amounts paid shall be the
18 amounts determined under section 1834(g) for outpatient
19 critical access hospital services”.

20 (c) EFFECTIVE DATE.—The amendments made by this
21 section apply to services furnished on or after the date of the
22 enactment of this Act.

23 **SEC. 206. GAO STUDY ON CERTAIN ELIGIBILITY RE-**
24 **QUIREMENTS FOR CRITICAL ACCESS HOS-**
25 **PITALS.**

26 (a) STUDY.—The Comptroller General of the United
27 States shall conduct a study on the eligibility requirements for
28 critical access hospitals under section 1820(c) of the Social Se-
29 curity Act (42 U.S.C. 1395i-4(c)) with respect to limitations
30 on average length of stay and number of beds in such a hos-
31 pital, including an analysis of—

32 (1) the feasibility of having a distinct part unit as part
33 of a critical access hospital for purposes of the medicare
34 program under title XVIII of such Act, and

35 (2) the effect of seasonal variations in patient admis-
36 sions on critical access hospital eligibility requirements with

1 respect to limitations on average annual length of stay and
2 number of beds.

3 (b) REPORT.—Not later than 1 year after the date of the
4 enactment of this Act, the Comptroller General shall submit to
5 Congress a report on the study conducted under subsection (a)
6 together with recommendations regarding—

7 (1) whether distinct part units should be permitted as
8 part of a critical access hospital under the medicare pro-
9 gram;

10 (2) if so permitted, the payment methodologies that
11 should apply with respect to services provided by such
12 units;

13 (3) whether, and to what extent, such units should be
14 included in or excluded from the bed limits applicable to
15 critical access hospitals under the medicare program; and

16 (4) any adjustments to such eligibility requirements to
17 account for seasonal variations in patient admissions.

18 **Subtitle B—Other Rural Hospitals** 19 **Provisions**

20 **SEC. 211. EQUITABLE TREATMENT FOR RURAL DIS-** 21 **PROPORTIONATE SHARE HOSPITALS.**

22 (a) APPLICATION OF UNIFORM THRESHOLD.—Section
23 1886(d)(5)(F)(v) (42 U.S.C. 1395ww(d)(5)(F)(v)) is
24 amended—

25 (1) in subclause (II), by inserting “(or 15 percent, for
26 discharges occurring on or after April 1, 2001)” after “30
27 percent”;

28 (2) in subclause (III), by inserting “(or 15 percent, for
29 discharges occurring on or after April 1, 2001)” after “40
30 percent”; and

31 (3) in subclause (IV), by inserting “(or 15 percent, for
32 discharges occurring on or after April 1, 2001)” after “45
33 percent”.

34 (b) ADJUSTMENT OF PAYMENT FORMULAS.—

35 (1) SOLE COMMUNITY HOSPITALS.—Section
36 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

32

1 (A) in clause (iv)(VI), by inserting after “10 per-
 2 cent” the following: “or, for discharges occurring on or
 3 after April 1, 2001, is equal to the percent determined
 4 in accordance with clause (x)”;

5 (B) by adding at the end the following new clause:
 6 “(x) For purposes of clause (iv)(VI) (relating to sole com-
 7 munity hospitals), in the case of a hospital for a cost reporting
 8 period with a disproportionate patient percentage (as defined in
 9 clause (vi)) that—

10 “(I) is less than 17.3, the disproportionate share ad-
 11 justment percentage is determined in accordance with the
 12 following formula: $(P-15)(.65) + 2.5$;

13 “(II) is equal to or exceeds 17.3, but is less than 30.0,
 14 such adjustment percentage is equal to 4 percent; or

15 “(III) is equal to or exceeds 30, such adjustment per-
 16 centage is equal to 10 percent,

17 where ‘P’ is the hospital’s disproportionate patient percentage
 18 (as defined in clause (vi)).”.

19 (2) RURAL REFERRAL CENTERS.—Such section is fur-
 20 ther amended—

21 (A) in clause (iv)(V), by inserting after “clause
 22 (viii)” the following: “or, for discharges occurring on or
 23 after April 1, 2001, is equal to the percent determined
 24 in accordance with clause (xi)”;

25 (B) by adding at the end the following new clause:
 26 “(xi) For purposes of clause (iv)(V) (relating to rural re-
 27 ferral centers), in the case of a hospital for a cost reporting
 28 period with a disproportionate patient percentage (as defined in
 29 clause (vi)) that—

30 “(I) is less than 17.3, the disproportionate share ad-
 31 justment percentage is determined in accordance with the
 32 following formula: $(P-15)(.65) + 2.5$;

33 “(II) is equal to or exceeds 17.3, but is less than 30.0,
 34 such adjustment percentage is equal to 4 percent; or

35 “(III) is equal to or exceeds 30, such adjustment per-
 36 centage is determined in accordance with the following for-
 37 mula: $(P-30)(.6) + 4$,

1 where 'P' is the hospital's disproportionate patient percentage
2 (as defined in clause (vi)).”.

3 (3) SMALL RURAL HOSPITALS GENERALLY.—Such sec-
4 tion is further amended—

5 (A) in clause (iv)(III), by inserting after “4 per-
6 cent” the following: “or, for discharges occurring on or
7 after April 1, 2001, is equal to the percent determined
8 in accordance with clause (xii)”;

9 (B) by adding at the end the following new clause:
10 “(xii) For purposes of clause (iv)(III) (relating to small
11 rural hospitals generally), in the case of a hospital for a cost
12 reporting period with a disproportionate patient percentage (as
13 defined in clause (vi)) that—

14 “(I) is less than 17.3, the disproportionate share ad-
15 justment percentage is determined in accordance with the
16 following formula: $(P-15)(.65) + 2.5$;

17 “(II) is equal to or exceeds 17.3, such adjustment per-
18 centage is equal to 4 percent,

19 where 'P' is the hospital's disproportionate patient percentage
20 (as defined in clause (vi)).”.

21 (4) HOSPITALS THAT ARE BOTH SOLE COMMUNITY
22 HOSPITALS AND RURAL REFERRAL CENTERS.—Such sec-
23 tion is further amended, in clause (iv)(IV), by inserting
24 after “clause (viii)” the following: “or, for discharges occur-
25 ring on or after April 1, 2001, the greater of the percent-
26 ages determined under clause (x) or (xi)”.

27 (5) URBAN HOSPITALS WITH LESS THAN 100 BEDS.—
28 Such section is further amended—

29 (A) in clause (iv)(II), by inserting after “5 per-
30 cent” the following: “or, for discharges occurring on or
31 after April 1, 2001, is equal to the percent determined
32 in accordance with clause (xiii)”;

33 (B) by adding at the end the following new clause:
34 “(xiii) For purposes of clause (iv)(II) (relating to urban
35 hospitals with less than 100 beds), in the case of a hospital for
36 a cost reporting period with a disproportionate patient percent-
37 age (as defined in clause (vi)) that—

1 “(I) is less than 17.3, the disproportionate share ad-
 2 justment percentage is determined in accordance with the
 3 following formula: $(P-15)(.65) + 2.5$;

4 “(II) is equal to or exceeds 17.3, but is less than 40.0,
 5 such adjustment percentage is equal to 4 percent; or

6 “(III) is equal to or exceeds 40, such adjustment per-
 7 centage is equal to 5 percent,

8 where ‘P’ is the hospital’s disproportionate patient percentage
 9 (as defined in clause (vi)).”.

10 **SEC. 212. OPTION TO BASE ELIGIBILITY FOR MEDICARE**
 11 **DEPENDENT, SMALL RURAL HOSPITAL PRO-**
 12 **GRAM ON DISCHARGES DURING 2 OF THE 3**
 13 **MOST RECENTLY AUDITED COST REPORT-**
 14 **ING PERIODS.**

15 (a) IN GENERAL.—Section 1886(d)(5)(G)(iv)(IV) (42
 16 U.S.C. 1395ww(d)(5)(G)(iv)(IV)) is amended by inserting “, or
 17 2 of the 3 most recently audited cost reporting periods for
 18 which the Secretary has a settled cost report,” after “1987”.

19 (b) EFFECTIVE DATE.—The amendment made by this sec-
 20 tion shall apply with respect to cost reporting periods beginning
 21 on or after April 1, 2001.

22 **SEC. 213. EXTENSION OF OPTION TO USE REBASED TAR-**
 23 **GET AMOUNTS TO ALL SOLE COMMUNITY**
 24 **HOSPITALS.**

25 (a) IN GENERAL.—Section 1886(b)(3)(I)(i) (42 U.S.C.
 26 1395ww(b)(3)(I)(i)) is amended—

27 (1) in the matter preceding subclause (I), by striking
 28 “that for its cost reporting period beginning during 1999”
 29 and all that follows through “for such target amount” and
 30 inserting “there shall be substituted for the amount other-
 31 wise determined under subsection (d)(5)(D)(i), if such sub-
 32 stitution results in a greater amount of payment under this
 33 section for the hospital”;

34 (2) in subclause (I), by striking “target amount other-
 35 wise applicable” and all that follows through “target
 36 amount’”) and inserting “the amount otherwise applicable
 37 to the hospital under subsection (d)(5)(D)(i) (referred to in
 38 this clause as the ‘subsection (d)(5)(D)(i) amount’)”; and

1 (3) in each of subclauses (II) and (III), by striking
 2 “subparagraph (C) target amount” and inserting “sub-
 3 section (d)(5)(D)(i) amount”.

4 (b) EFFECTIVE DATE.—The amendments made by this
 5 section shall take effect as if included in the enactment of sec-
 6 tion 405 of BBRA (113 Stat. 1501A–372).

7 **SEC. 214. MEDPAC ANALYSIS OF IMPACT OF VOLUME ON**
 8 **PER UNIT COST OF RURAL HOSPITALS WITH**
 9 **PSYCHIATRIC UNITS.**

10 The Medicare Payment Advisory Commission, in its study
 11 conducted pursuant to subsection (a) of section 411 of BBRA
 12 (113 Stat. 1501A–377), shall include—

13 (1) in such study an analysis of the impact of volume
 14 on the per unit cost of rural hospitals with psychiatric
 15 units; and

16 (2) in its report under subsection (b) of such section
 17 a recommendation on whether special treatment for such
 18 hospitals may be warranted.

19 **Subtitle C—Other Rural Provisions**

20 **SEC. 221. ASSISTANCE FOR PROVIDERS OF AMBULANCE**
 21 **SERVICES IN RURAL AREAS.**

22 (a) TRANSITIONAL ASSISTANCE IN CERTAIN MILEAGE
 23 RATES.—Section 1834(l) (42 U.S.C. 1395m(l)) is amended by
 24 adding at the end the following new paragraph:

25 “(8) TRANSITIONAL ASSISTANCE FOR RURAL PRO-
 26 VIDERS.—In the case of ground ambulance services fur-
 27 nished on or after the date on which the Secretary imple-
 28 ments the fee schedule under this subsection and before
 29 January 1, 2004, for which the transportation originates in
 30 a rural area (as defined in section 1886(d)(2)(D)) or in a
 31 rural census tract of a metropolitan statistical area (as de-
 32 termined under the most recent modification of the Gold-
 33 smith Modification, originally published in the Federal Reg-
 34 ister on February 27, 1992 (57 Fed. Reg. 6725)), the fee
 35 schedule established under this subsection shall provide
 36 that, with respect to the payment rate for mileage for a
 37 trip above 17 miles, and up to 50 miles, the rate otherwise

36

1 established shall be increased by not less than $\frac{1}{2}$ of the ad-
2 ditional payment per mile established for the first 17 miles
3 of such a trip originating in a rural area.”.

4 (b) GAO STUDIES ON THE COSTS OF AMBULANCE SERV-
5 ICES FURNISHED IN RURAL AREAS.—

6 (1) STUDY.—The Comptroller General of the United
7 States shall conduct a study on each of the matters de-
8 scribed in paragraph (2).

9 (2) MATTERS DESCRIBED.—The matters referred to in
10 paragraph (1) are the following:

11 (A) The cost of efficiently providing ambulance
12 services for trips originating in rural areas, with special
13 emphasis on collection of cost data from rural pro-
14 viders.

15 (B) The means by which rural areas with low pop-
16 ulation densities can be identified for the purpose of
17 designating areas in which the cost of providing ambu-
18 lance services would be expected to be higher than simi-
19 lar services provided in more heavily populated areas
20 because of low usage. Such study shall also include an
21 analysis of the additional costs of providing ambulance
22 services in areas designated under the previous sen-
23 tence.

24 (3) REPORT.—Not later than June 30, 2002, the
25 Comptroller General shall submit to Congress a report on
26 the results of the studies conducted under paragraph (1)
27 and shall include recommendations on steps that should be
28 taken to assure access to ambulance services in rural areas.

29 (c) ADJUSTMENT IN RURAL RATES.—In providing for ad-
30 justments under subparagraph (D) of section 1834(l)(2) of the
31 Social Security Act (42 U.S.C. 1395m(l)(2)) for years begin-
32 ning with 2004, the Secretary of Health and Human Services
33 shall take into consideration the recommendations contained in
34 the report under subsection (b)(2) and shall adjust the fee
35 schedule payment rates under such section for ambulance serv-
36 ices provided in low density rural areas based on the increased
37 cost (if any) of providing such services in such areas.

1 (d) EFFECTIVE DATE.—The amendment made by sub-
2 section (a) applies to services furnished on or after the date the
3 Secretary implements the fee schedule under section 1834(l) of
4 the Social Security Act (42 U.S.C. 1395m(l)). In applying such
5 amendment to services furnished on or after such date and be-
6 fore January 1, 2002, the amount of the rate increase provided
7 under such amendment shall be equal to \$1.25 per mile.

8 **SEC. 222. PAYMENT FOR CERTAIN PHYSICIAN ASSIST-**
9 **ANT SERVICES.**

10 (a) PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT SERV-
11 ICES.—Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is
12 amended—

13 (1) by striking “for such services provided before Jan-
14 uary 1, 2003,”; and

15 (2) by striking the semicolon at the end and inserting
16 a comma.

17 (b) EFFECTIVE DATE.—The amendments made by sub-
18 section (a) shall take effect on the date of the enactment of this
19 Act.

20 **SEC. 223. REVISION OF MEDICARE REIMBURSEMENT**
21 **FOR TELEHEALTH SERVICES.**

22 (a) TIME LIMIT FOR BBA PROVISION.—Section 4206(a)
23 of BBA (42 U.S.C. 1395l note) is amended by striking “Not
24 later than January 1, 1999” and inserting “For services fur-
25 nished on and after January 1, 1999, and before July 1,
26 2001”.

27 (b) EXPANSION OF MEDICARE PAYMENT FOR TELE-
28 HEALTH SERVICES.—Section 1834 (42 U.S.C. 1395m) is
29 amended by adding at the end the following new subsection:

30 “(m) PAYMENT FOR TELEHEALTH SERVICES.—

31 “(1) IN GENERAL.—The Secretary shall pay for tele-
32 health services that are furnished via a telecommunications
33 system by a physician (as defined in section 1861(r)) or a
34 practitioner (described in section 1842(b)(18)(C)) to an eli-
35 gible telehealth individual enrolled under this part notwith-
36 standing that the individual physician or practitioner pro-
37 viding the telehealth service is not at the same location as

38

1 the beneficiary. For purposes of the preceding sentence, in
2 the case of any Federal telemedicine demonstration pro-
3 gram conducted in Alaska or Hawaii, the term ‘tele-
4 communications system’ includes store-and-forward tech-
5 nologies that provide for the asynchronous transmission of
6 health care information in single or multimedia formats.

7 “(2) PAYMENT AMOUNT.—

8 “(A) DISTANT SITE.—The Secretary shall pay to
9 a physician or practitioner located at a distant site that
10 furnishes a telehealth service to an eligible telehealth
11 individual an amount equal to the amount that such
12 physician or practitioner would have been paid under
13 this title had such service been furnished without the
14 use of a telecommunications system.

15 “(B) FACILITY FEE FOR ORIGINATING SITE.—
16 With respect to a telehealth service, subject to section
17 1833(a)(1)(U), there shall be paid to the originating
18 site a facility fee equal to—

19 “(i) for the period beginning on July 1, 2001,
20 and ending on December 31, 2001, and for 2002,
21 \$20; and

22 “(ii) for a subsequent year, the facility fee
23 specified in clause (i) or this clause for the pre-
24 ceding year increased by the percentage increase in
25 the MEI (as defined in section 1842(i)(3)) for such
26 subsequent year.

27 “(C) TELEPRESENTER NOT REQUIRED.—Nothing
28 in this subsection shall be construed as requiring an el-
29 igible telehealth individual to be presented by a physi-
30 cian or practitioner at the originating site for the fur-
31 nishing of a service via a telecommunications system,
32 unless it is medically necessary (as determined by the
33 physician or practitioner at the distant site).

34 “(3) LIMITATION ON BENEFICIARY CHARGES.—

35 “(A) PHYSICIAN AND PRACTITIONER.—The provi-
36 sions of section 1848(g) and subparagraphs (A) and
37 (B) of section 1842(b)(18) shall apply to a physician

1 or practitioner receiving payment under this subsection
2 in the same manner as they apply to physicians or
3 practitioners under such sections.

4 “(B) ORIGINATING SITE.—The provisions of sec-
5 tion 1842(b)(18) shall apply to originating sites receiv-
6 ing a facility fee in the same manner as they apply to
7 practitioners under such section.

8 “(4) DEFINITIONS.—For purposes of this subsection:

9 “(A) DISTANT SITE.—The term ‘distant site’
10 means the site at which the physician or practitioner is
11 located at the time the service is provided via a tele-
12 communications system.

13 “(B) ELIGIBLE TELEHEALTH INDIVIDUAL.—The
14 term ‘eligible telehealth individual’ means an individual
15 enrolled under this part who receives a telehealth serv-
16 ice furnished at an originating site.

17 “(C) ORIGINATING SITE.—

18 “(i) IN GENERAL.—The term ‘originating site’
19 means only those sites described in clause (ii) at
20 which the eligible telehealth individual is located at
21 the time the service is furnished via a telecommuni-
22 cations system and only if such site is located—

23 “(I) in an area that is designated as a
24 rural health professional shortage area under
25 section 332(a)(1)(A) of the Public Health Serv-
26 ice Act (42 U.S.C. 254e(a)(1)(A));

27 “(II) in a county that is not included in a
28 Metropolitan Statistical Area; or

29 “(III) from an entity that participates in
30 a Federal telemedicine demonstration project
31 that has been approved by (or receives funding
32 from) the Secretary of Health and Human
33 Services as of December 31, 2000.

34 “(ii) SITES DESCRIBED.—The sites referred to
35 in clause (i) are the following sites:

36 “(I) The office of a physician or practi-
37 tioner.

40

1 “(II) A critical access hospital (as defined
2 in section 1861(mm)(1)).

3 “(III) A rural health clinic (as defined in
4 section 1861(aa)(s)).

5 “(IV) A Federally qualified health center
6 (as defined in section 1861(aa)(4)).

7 “(V) A hospital (as defined in section
8 1861(e)).

9 “(D) PHYSICIAN.—The term ‘physician’ has
10 the meaning given that term in section 1861(r).

11 “(E) PRACTITIONER.—The term ‘practitioner’
12 has the meaning given that term in section
13 1842(b)(18)(C).

14 “(F) TELEHEALTH SERVICE.—

15 “(i) IN GENERAL.—The term ‘telehealth serv-
16 ice’ means professional consultations, office visits,
17 and office psychiatry services (identified as of July
18 1, 2000, by HCPCS codes 99241–99275, 99201–
19 99215, 90804–90809, and 90862 (and as subse-
20 quently modified by the Secretary)), and any addi-
21 tional service specified by the Secretary.

22 “(ii) YEARLY UPDATE.—The Secretary shall
23 establish a process that provides, on an annual
24 basis, for the addition or deletion of services (and
25 HCPCS codes), as appropriate, to those specified
26 in clause (i) for authorized payment under para-
27 graph (1).”.

28 (c) CONFORMING AMENDMENT.—Section 1833(a)(1) (42
29 U.S.C. 1395l(1)), as amended by section 105(c), is further
30 amended—

31 (1) by striking “and (T)” and inserting “(T)”; and

32 (2) by inserting before the semicolon at the end the
33 following: “, and (U) with respect to facility fees described
34 in section 1834(m)(2)(B), the amounts paid shall be 80
35 percent of the lesser of the actual charge or the amounts
36 specified in such section”.

37 (d) STUDY AND REPORT ON ADDITIONAL COVERAGE.—

1 (1) STUDY.—The Secretary of Health and Human
2 Services shall conduct a study to identify—

3 (A) settings and sites for the provision of tele-
4 health services that are in addition to those permitted
5 under section 1834(m) of the Social Security Act, as
6 added by subsection (b);

7 (B) practitioners that may be reimbursed under
8 such section for furnishing telehealth services that are
9 in addition to the practitioners that may be reimbursed
10 for such services under such section; and

11 (C) geographic areas in which telehealth services
12 may be reimbursed that are in addition to the geo-
13 graphic areas where such services may be reimbursed
14 under such section.

15 (2) REPORT.—Not later than 2 years after the date of
16 the enactment of this Act, the Secretary shall submit to
17 Congress a report on the study conducted under paragraph
18 (1) together with such recommendations for legislation that
19 the Secretary determines are appropriate.

20 (e) EFFECTIVE DATE.—The amendments made by sub-
21 sections (b) and (c) shall be effective for services furnished on
22 or after July 1, 2001.

23 **SEC. 224. EXPANDING ACCESS TO RURAL HEALTH CLIN-**
24 **ICS.**

25 (a) IN GENERAL.—The matter in section 1833(f) (42
26 U.S.C. 1395l(f)) preceding paragraph (1) is amended by strik-
27 ing “rural hospitals” and inserting “hospitals”.

28 (b) EFFECTIVE DATE.—The amendment made by sub-
29 section (a) shall apply to services furnished on or after July 1,
30 2001.

31 **SEC. 225. MEDPAC STUDY ON LOW-VOLUME, ISOLATED**
32 **RURAL HEALTH CARE PROVIDERS.**

33 (a) STUDY.—The Medicare Payment Advisory Commission
34 shall conduct a study on the effect of low patient and procedure
35 volume on the financial status of low-volume, isolated rural
36 health care providers participating in the medicare program
37 under title XVIII of the Social Security Act.

1 (b) REPORT.—Not later than 18 months after the date of
2 the enactment of this Act, the Commission shall submit to Con-
3 gress a report on the study conducted under subsection (a)
4 indicating—

5 (1) whether low-volume, isolated rural health care pro-
6 viders are having, or may have, significantly decreased
7 medicare margins or other financial difficulties resulting
8 from any of the payment methodologies described in sub-
9 section (c);

10 (2) whether the status as a low-volume, isolated rural
11 health care provider should be designated under the medi-
12 care program and any criteria that should be used to qual-
13 ify for such a status; and

14 (3) any changes in the payment methodologies de-
15 scribed in subsection (c) that are necessary to provide ap-
16 propriate reimbursement under the medicare program to
17 low-volume, isolated rural health care providers (as des-
18 ignated pursuant to paragraph (2)).

19 (c) PAYMENT METHODOLOGIES DESCRIBED.—The pay-
20 ment methodologies described in this subsection are the fol-
21 lowing:

22 (1) The prospective payment system for hospital out-
23 patient department services under section 1833(t) of the
24 Social Security Act (42 U.S.C. 1395l(t)).

25 (2) The fee schedule for ambulance services under sec-
26 tion 1834(l) of such Act (42 U.S.C. 1395m(l)).

27 (3) The prospective payment system for inpatient hos-
28 pital services under section 1886 of such Act (42 U.S.C.
29 1395ww).

30 (4) The prospective payment system for routine service
31 costs of skilled nursing facilities under section 1888(e) of
32 such Act (42 U.S.C. 1395yy(e)).

33 (5) The prospective payment system for home health
34 services under section 1895 of such Act (42 U.S.C.
35 1395fff).

1 **TITLE III—PROVISIONS RELATING**
 2 **TO PART A**
 3 **Subtitle A—Inpatient Hospital**
 4 **Services**

5 **SEC. 301. REVISION OF ACUTE CARE HOSPITAL PAY-**
 6 **MENT UPDATE FOR 2001.**

7 (a) IN GENERAL.—Section 1886(b)(3)(B)(i) (42 U.S.C.
 8 1395ww(b)(3)(B)(i)) is amended—

9 (1) in subclause (XVI), by striking “minus 1.1 per-
 10 centage points for hospitals (other than sole community
 11 hospitals) in all areas, and the market basket percentage
 12 increase for sole community hospitals,” and inserting “for
 13 hospitals in all areas,”;

14 (2) in subclause (XVII)—

15 (A) by striking “minus 1.1 percentage points” and
 16 inserting “minus 0.55 percentage points; and

17 (B) by striking “and” at the end;

18 (3) by redesignating subclause (XVIII) as subclause
 19 (XIX);

20 (4) in subclause (XIX), as so redesignated, by striking
 21 “fiscal year 2003” and inserting “fiscal year 2004”; and

22 (5) by inserting after subclause (XVII) the following
 23 new subclause:

24 “(XVIII) for fiscal year 2003, the market basket per-
 25 centage increase minus 0.55 percentage points for hospitals
 26 in all areas, and”.

27 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR
 28 2001.—Notwithstanding the amendment made by subsection
 29 (a), for purposes of making payments for fiscal year 2001 for
 30 inpatient hospital services furnished by subsection (d) hospitals
 31 (as defined in section 1886(d)(1)(B) of the Social Security Act
 32 (42 U.S.C. 1395ww(d)(1)(B)), the “applicable percentage in-
 33 crease” referred to in section 1886(b)(3)(B)(i) of such Act (42
 34 U.S.C. 1395ww(b)(3)(B)(i))—

35 (1) for discharges occurring on or after October 1,
 36 2000, and before April 1, 2001, shall be determined in ac-

1 cordance with subclause (XVI) of such section as in effect
2 on the day before the date of the enactment of this Act;
3 and

4 (2) for discharges occurring on or after April 1, 2001,
5 and before October 1, 2001, shall be equal to—

6 (A) the market basket percentage increase plus
7 1.1 percentage points for hospitals (other than sole
8 community hospitals) in all areas; and

9 (B) the market basket percentage increase for sole
10 community hospitals.

11 (c) CONSIDERATION OF PRICE OF BLOOD AND BLOOD
12 PRODUCTS IN MARKET BASKET INDEX.—The Secretary of
13 Health and Human Services shall, when next (after the date
14 of the enactment of this Act) rebasing and revising the hospital
15 market basket index (as defined in section 1886(b)(3)(B)(iii) of
16 the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii))), con-
17 sider the prices of blood and blood products purchased by hos-
18 pitals and determine whether those prices are adequately re-
19 flected in such index.

20 (d) MEDPAC STUDY AND REPORT REGARDING CERTAIN
21 HOSPITAL COSTS.—

22 (1) STUDY.—The Medicare Payment Advisory Com-
23 mission shall conduct a study on—

24 (A) any increased costs incurred by subsection (d)
25 hospitals (as defined in paragraph (1)(B) of section
26 1886(d) of the Social Security Act (42 U.S.C.
27 1395ww(d))) in providing inpatient hospital services to
28 medicare beneficiaries under title XVIII of such Act
29 during the period beginning on October 1, 1983, and
30 ending on September 30, 1999, that were attributable
31 to—

32 (i) complying with new blood safety measure
33 requirements; and

34 (ii) providing such services using new tech-
35 nologies;

36 (B) the extent to which the prospective payment
37 system for such services under such section provides

1 adequate and timely recognition of such increased
2 costs;

3 (C) the prospects for (and to the extent prac-
4 ticable, the magnitude of) cost increases that hospitals
5 will incur in providing such services that are attrib-
6 utable to complying with new blood safety measure re-
7 quirements and providing such services using new tech-
8 nologies during the 10 years after the date of the en-
9 actment of this Act; and

10 (D) the feasibility and advisability of establishing
11 mechanisms under such payment system to provide for
12 more timely and accurate recognition of such cost in-
13 creases in the future.

14 (2) CONSULTATION.—In conducting the study under
15 this subsection, the Commission shall consult with rep-
16 resentatives of the blood community, including—

17 (A) hospitals;

18 (B) organizations involved in the collection, proc-
19 essing, and delivery of blood; and

20 (C) organizations involved in the development of
21 new blood safety technologies.

22 (3) REPORT.—Not later than 1 year after the date of
23 the enactment of this Act, the Commission shall submit to
24 Congress a report on the study conducted under paragraph
25 (1) together with such recommendations for legislation and
26 administrative action as the Commission determines appro-
27 priate.

28 (e) ADJUSTMENT FOR INPATIENT CASE MIX CHANGES.—

29 (1) IN GENERAL.—Section 1886(d)(3)(A) (42 U.S.C.
30 1395ww(d)(3)(A)) is amended by adding at the end the fol-
31 lowing new clause:

32 “(vi) Insofar as the Secretary determines that the ad-
33 justments under paragraph (4)(C)(i) for a previous fiscal
34 year (or estimates that such adjustments for a future fiscal
35 year) did (or are likely to) result in a change in aggregate
36 payments under this subsection during the fiscal year that
37 are a result of changes in the coding or classification of dis-

1 charges that do not reflect real changes in case mix, the
2 Secretary may adjust the average standardized amounts
3 computed under this paragraph for subsequent fiscal years
4 so as to eliminate the effect of such coding or classification
5 changes.”.

6 (2) EFFECTIVE DATE.—The amendment made by
7 paragraph (1) applies to discharges occurring on or after
8 October 1, 2001.

9 **SEC. 302. ADDITIONAL MODIFICATION IN TRANSITION**
10 **FOR INDIRECT MEDICAL EDUCATION (IME)**
11 **PERCENTAGE ADJUSTMENT.**

12 (a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C.
13 1395ww(d)(5)(B)(ii)) is amended—

14 (1) in subclause (V) by striking “and” at the end;

15 (2) by redesignating subclause (VI) as subclause (VII);

16 (3) in subclause (VII) as so redesignated, by striking
17 “2001” and inserting “2002”; and

18 (4) by inserting after subclause (V) the following new
19 subclause:

20 “(VI) during fiscal year 2002, ‘c’ is equal to 1.57;
21 and”.

22 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR
23 2001.—Notwithstanding paragraph (5)(B)(ii)(V) of section
24 1886(d) of the Social Security Act (42 U.S.C.
25 1395ww(d)(5)(B)(ii)(V)), for purposes of making payments for
26 subsection (d) hospitals (as defined in paragraph (1)(B) of
27 such section) with indirect costs of medical education, the indi-
28 rect teaching adjustment factor referred to in paragraph
29 (5)(B)(ii) of such section shall be determined, for discharges
30 occurring on or after April 1, 2001, and before October 1,
31 2001, as if “c” in paragraph (5)(B)(ii)(V) of such section
32 equalled 1.66 rather than 1.54.

33 (c) CONFORMING AMENDMENT RELATING TO DETERMINA-
34 TION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i)
35 (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by inserting “or of
36 section 302 of the Medicare, Medicaid, and SCHIP Benefits

1 Improvement and Protection Act of 2000” after “Balanced
2 Budget Refinement Act of 1999”.

3 (d) CLERICAL AMENDMENTS.—Section 1886(d)(5)(B) (42
4 U.S.C. 1395ww(d)(5)(B)), as amended by subsection (a), is
5 further amended by moving the indentation of each of the fol-
6 lowing 2 ems to the left:

7 (1) Clauses (ii), (v), and (vi).

8 (2) Subclauses (I) (II), (III), (IV), (V), and (VII) of
9 clause (ii).

10 (3) Subclauses (I) and (II) of clause (vi) and the flush
11 sentence at the end of such clause.

12 **SEC. 303. DECREASE IN REDUCTIONS FOR DISPROPOR-**
13 **TIONATE SHARE HOSPITAL (DSH) PAY-**
14 **MENTS.**

15 (a) IN GENERAL.—Section 1886(d)(5)(F)(ix) (42 U.S.C.
16 1395ww(d)(5)(F)(ix)) is amended—

17 (1) in subclause (III), by striking “each of” and by in-
18 serting “and 2 percent, respectively” after “3 percent”; and

19 (2) in subclause (IV), by striking “4 percent” and in-
20 serting “3 percent”.

21 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR
22 2001.—Notwithstanding the amendment made by subsection
23 (a)(1), for purposes of making disproportionate share payments
24 for subsection (d) hospitals (as defined in section
25 1886(d)(1)(B) of the Social Security Act (42 U.S.C.
26 1395ww(d)(1)(B)) for fiscal year 2001, the additional payment
27 amount otherwise determined under clause (ii) of section
28 1886(d)(5)(F) of the Social Security Act (42 U.S.C.
29 1395ww(d)(5)(F))—

30 (1) for discharges occurring on or after October 1,
31 2000, and before April 1, 2001, shall be adjusted as pro-
32 vided by clause (ix)(III) of such section as in effect on the
33 day before the date of the enactment of this Act; and

34 (2) for discharges occurring on or after April 1, 2001,
35 and before October 1, 2001, shall, instead of being reduced
36 by 3 percent as provided by clause (ix)(III) of such section

1 as in effect after the date of the enactment of this Act, be
2 reduced by 1 percent.

3 (c) CONFORMING AMENDMENTS RELATING TO DETER-
4 MINATION OF STANDARDIZED AMOUNT.—Section
5 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)), is
6 amended—

7 (1) by striking “1989 or” and inserting “1989,”; and
8 (2) by inserting “, or the enactment of section 303 of
9 the Medicare, Medicaid, and SCHIP Benefits Improvement
10 and Protection Act of 2000” after “Omnibus Budget Rec-
11 onciliation Act of 1990”.

12 (d) TECHNICAL AMENDMENT.—

13 (1) IN GENERAL.—Section 1886(d)(5)(F)(i) (42
14 U.S.C. 1395ww(d)(5)(F)(i)) is amended by striking “and
15 before October 1, 1997,”.

16 (2) EFFECTIVE DATE.—The amendment made by
17 paragraph (1) is effective as if included in the enactment
18 of BBA.

19 (e) REFERENCE TO CHANGES IN DSH FOR RURAL HOS-
20 PITALS.—For additional changes in the DSH program for rural
21 hospitals, see section 211.

22 **SEC. 304. WAGE INDEX IMPROVEMENTS.**

23 (a) DURATION OF WAGE INDEX RECLASSIFICATION; USE
24 OF 3-YEAR WAGE DATA.—Section 1886(d)(10)(D) (42 U.S.C.
25 1395ww(d)(10)(D)) is amended by adding at the end the fol-
26 lowing new clauses:

27 “(v) Any decision of the Board to reclassify a subsection
28 (d) hospital for purposes of the adjustment factor described in
29 subparagraph (C)(i)(II) for fiscal year 2001 or any fiscal year
30 thereafter shall be effective for a period of 3 fiscal years, except
31 that the Secretary shall establish procedures under which a
32 subsection (d) hospital may elect to terminate such reclassifica-
33 tion before the end of such period.

34 “(vi) Such guidelines shall provide that, in making deci-
35 sions on applications for reclassification for the purposes de-
36 scribed in clause (v) for fiscal year 2003 and any succeeding
37 fiscal year, the Board shall base any comparison of the average

1 hourly wage for the hospital with the average hourly wage for
2 hospitals in an area on—

3 “(I) an average of the average hourly wage amount for
4 the hospital from the most recently published hospital wage
5 survey data of the Secretary (as of the date on which the
6 hospital applies for reclassification) and such amount from
7 each of the two immediately preceding surveys; and

8 “(II) an average of the average hourly wage amount
9 for hospitals in such area from the most recently published
10 hospital wage survey data of the Secretary (as of the date
11 on which the hospital applies for reclassification) and such
12 amount from each of the two immediately preceding sur-
13 veys.”.

14 (b) PROCESS TO PERMIT STATEWIDE WAGE INDEX CAL-
15 CULATION AND APPLICATION.—

16 (1) IN GENERAL.—The Secretary of Health and
17 Human Services shall establish a process (based on the vol-
18 untary process utilized by the Secretary of Health and
19 Human Services under section 1848 of the Social Security
20 Act (42 U.S.C. 1395w-4) for purposes of computing and
21 applying a statewide geographic wage index) under which
22 an appropriate statewide entity may apply to have all the
23 geographic areas in a State treated as a single geographic
24 area for purposes of computing and applying the area wage
25 index under section 1886(d)(3)(E) of such Act (42 U.S.C.
26 1395ww(d)(3)(E)). Such process shall be established by Oc-
27 tober 1, 2001, for reclassifications beginning in fiscal year
28 2003.

29 (2) PROHIBITION ON INDIVIDUAL HOSPITAL RECLASSI-
30 FICATION.—Notwithstanding any other provision of law, if
31 the Secretary applies a statewide geographic wage index
32 under paragraph (1) with respect to a State, any applica-
33 tion submitted by a hospital in that State under section
34 1886(d)(10) of the Social Security Act (42 U.S.C.
35 1395ww(d)(10)) for geographic reclassification shall not be
36 considered.

50

1 (c) COLLECTION OF INFORMATION ON OCCUPATIONAL
2 MIX.—

3 (1) IN GENERAL.—The Secretary of Health and
4 Human Services shall provide for the collection of data
5 every 3 years on occupational mix for employees of each
6 subsection (d) hospital (as defined in section 1886(d)(1)(D)
7 of the Social Security Act (42 U.S.C. 1395ww(d)(1)(D)))
8 in the provision of inpatient hospital services, in order to
9 construct an occupational mix adjustment in the hospital
10 area wage index applied under section 1886(d)(3)(E) of
11 such Act (42 U.S.C. 1395ww(d)(3)(E)).

12 (2) APPLICATION.—The third sentence of section
13 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended
14 by striking “To the extent determined feasible by the Sec-
15 retary, such survey shall measure” and inserting “Not less
16 often than once every 3 years the Secretary (through such
17 survey or otherwise) shall measure”.

18 (3) EFFECTIVE DATE.—By not later than September
19 30, 2003, for application beginning October 1, 2004, the
20 Secretary shall first complete—

21 (A) the collection of data under paragraph (1);
22 and

23 (B) the measurement under the third sentence of
24 section 1886(d)(3)(E), as amended by paragraph (2).

25 **SEC. 305. PAYMENT FOR INPATIENT SERVICES OF REHA-**
26 **BILITATION HOSPITALS.**

27 (a) ASSISTANCE WITH ADMINISTRATIVE COSTS ASSOCI-
28 ATED WITH COMPLETION OF PATIENT ASSESSMENT.—Section
29 1886(j)(3)(B) (42 U.S.C. 1395ww(j)(3)(B)) is amended by
30 striking “98 percent” and inserting “98 percent for fiscal year
31 2001 and 100 percent for fiscal year 2002”.

32 (b) ELECTION TO APPLY FULL PROSPECTIVE PAYMENT
33 RATE WITHOUT PHASE-IN.—

34 (1) IN GENERAL.—Paragraph (1) of section 1886(j)
35 (42 U.S.C. 1395ww(j)) is amended—

1 (A) in subparagraph (A), by inserting “other than
2 a facility making an election under subparagraph (F)”
3 before “in a cost reporting period”;

4 (B) in subparagraph (B), by inserting “or, in the
5 case of a facility making an election under subpara-
6 graph (F), for any cost reporting period described in
7 such subparagraph,” after “2002,”; and

8 (C) by adding at the end the following new sub-
9 paragraph:

10 “(F) ELECTION TO APPLY FULL PROSPECTIVE
11 PAYMENT SYSTEM.—A rehabilitation facility may elect,
12 not later than 30 days before its first cost reporting pe-
13 riod for which the payment methodology under this
14 subsection applies to the facility, to have payment made
15 to the facility under this subsection under the provi-
16 sions of subparagraph (B) (rather than subparagraph
17 (A)) for each cost reporting period to which such pay-
18 ment methodology applies.”.

19 (2) CLARIFICATION.—Paragraph (3)(B) of such sec-
20 tion is amended by inserting “but not taking into account
21 any payment adjustment resulting from an election per-
22 mitted under paragraph (1)(F)” after “paragraphs (4) and
23 (6)”.

24 (c) EFFECTIVE DATE.—The amendments made by this
25 section take effect as if included in the enactment of BBA.

26 **SEC. 306. PAYMENT FOR INPATIENT SERVICES OF PSY-**
27 **CHIATRIC HOSPITALS.**

28 With respect to hospitals described in clause (i) of section
29 1886(d)(1)(B) of the Social Security Act (42 U.S.C.
30 1395ww(d)(1)(B)) and psychiatric units described in the mat-
31 ter following clause (v) of such section, in making incentive
32 payments to such hospitals under section 1886(b)(1)(A) of
33 such Act (42 U.S.C. 1395ww(b)(1)(A)) for cost reporting peri-
34 ods beginning on or after October 1, 2000, and before October
35 1, 2001, the Secretary of Health and Human Services, in
36 clause (ii) of such section, shall substitute “3 percent” for “2
37 percent”.

1 **SEC. 307. PAYMENT FOR INPATIENT SERVICES OF LONG-**
2 **TERM CARE HOSPITALS.**

3 (a) INCREASED TARGET AMOUNTS AND CAPS FOR LONG-
4 TERM CARE HOSPITALS BEFORE IMPLEMENTATION OF THE
5 PROSPECTIVE PAYMENT SYSTEM.—

6 (1) IN GENERAL.—Section 1886(b)(3) (42 U.S.C.
7 1395ww(b)(3)) is amended—

8 (A) in subparagraph (H)(ii)(III), by inserting
9 “subject to subparagraph (J),” after “2002,”; and

10 (B) by adding at the end the following new sub-
11 paragraph:

12 “(J) For cost reporting periods beginning during fiscal
13 year 2001, for a hospital described in subsection
14 (d)(1)(B)(iv)—

15 “(i) the limiting or cap amount otherwise determined
16 under subparagraph (H) shall be increased by 2 percent;
17 and

18 “(ii) the target amount otherwise determined under
19 subparagraph (A) shall be increased by 25 percent (subject
20 to the limiting or cap amount determined under subpara-
21 graph (H), as increased by clause (i)).”.

22 (2) APPLICATION.—The amendments made by sub-
23 section (a) and by section 122 of BBRA (113 Stat. 1501A-
24 331) shall not be taken into account in the development
25 and implementation of the prospective payment system
26 under section 123 of BBRA (113 Stat. 1501A-331).

27 (b) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYS-
28 TEM FOR LONG-TERM CARE HOSPITALS.—

29 (1) MODIFICATION OF REQUIREMENT.—In developing
30 the prospective payment system for payment for inpatient
31 hospital services provided in long-term care hospitals de-
32 scribed in section 1886(d)(1)(B)(iv) of the Social Security
33 Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare
34 program under title XVIII of such Act required under sec-
35 tion 123 of BBRA, the Secretary of Health and Human
36 Services shall examine the feasibility and the impact of bas-
37 ing payment under such a system on the use of existing (or

1 refined) hospital diagnosis-related groups (DRGs) that
 2 have been modified to account for different resource use of
 3 long-term care hospital patients as well as the use of the
 4 most recently available hospital discharge data. The Sec-
 5 retary shall examine and may provide for appropriate ad-
 6 justments to the long-term hospital payment system, in-
 7 cluding adjustments to DRG weights, area wage adjust-
 8 ments, geographic reclassification, outliers, updates, and a
 9 disproportionate share adjustment consistent with section
 10 1886(d)(5)(F) of the Social Security Act (42 U.S.C.
 11 1395ww(d)(5)(F)).

12 (2) DEFAULT IMPLEMENTATION OF SYSTEM BASED
 13 ON EXISTING DRG METHODOLOGY.—If the Secretary is un-
 14 able to implement the prospective payment system under
 15 section 123 of the BBRA by October 1, 2002, the Sec-
 16 retary shall implement a prospective payment system for
 17 such hospitals that bases payment under such a system
 18 using existing hospital diagnosis-related groups (DRGs),
 19 modified where feasible to account for resource use of long-
 20 term care hospital patients using the most recently avail-
 21 able hospital discharge data for such services furnished on
 22 or after that date.

23 **Subtitle B—Adjustments to PPS Pay-** 24 **ments for Skilled Nursing Facilities**

25 **SEC. 311. ELIMINATION OF REDUCTION IN SKILLED** 26 **NURSING FACILITY (SNF) MARKET BASKET** 27 **UPDATE IN 2001.**

28 (a) IN GENERAL.—Section 1888(e)(4)(E)(ii) (42 U.S.C.
 29 1395yy(e)(4)(E)(ii)) is amended—

30 (1) by redesignating subclauses (II) and (III) as sub-
 31 clauses (III) and (IV), respectively;

32 (2) in subclause (III), as so redesignated—

33 (A) by striking “each of fiscal years 2001 and
 34 2002” and inserting “each of fiscal years 2002 and
 35 2003”; and

36 (B) by striking “minus 1 percentage point” and
 37 inserting “minus 0.5 percentage points”; and

1 (3) by inserting after subclause (I) the following new
2 subclause:

3 “(II) for fiscal year 2001, the rate com-
4 puted for the previous fiscal year increased by
5 the skilled nursing facility market basket per-
6 centage change for the fiscal year;”.

7 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR
8 2001.—Notwithstanding the amendments made by subsection
9 (a), for purposes of making payments for covered skilled nurs-
10 ing facility services under section 1888(e) of the Social Security
11 Act (42 U.S.C. 1395yy(e)) for fiscal year 2001, the Federal per
12 diem rate referred to in paragraph (4)(E)(ii) of such section—

13 (1) for the period beginning on October 1, 2000, and
14 ending on March 31, 2001, shall be the rate determined in
15 accordance with the law as in effect on the day before the
16 date of the enactment of this Act; and

17 (2) for the period beginning on April 1, 2001, and
18 ending on September 30, 2001, shall be the rate that would
19 have been determined under such section if “plus 1 per-
20 centage point” had been substituted for “minus 1 percent-
21 age point” under subclause (II) of such paragraph (as in
22 effect on the day before the date of the enactment of this
23 Act).

24 (c) RELATION TO TEMPORARY INCREASE IN BBRA.—The
25 increases provided under section 101 of BBRA (113 Stat.
26 1501A–325) shall be in addition to any increase resulting from
27 the amendments made by subsection (a).

28 (d) GAO REPORT ON ADEQUACY OF SNF PAYMENT
29 RATES.—Not later than July 1, 2002, the Comptroller General
30 of the United States shall submit to Congress a report on the
31 adequacy of medicare payment rates to skilled nursing facilities
32 and the extent to which medicare contributes to the financial
33 viability of such facilities. Such report shall take into account
34 the role of private payors, medicaid, and case mix on the finan-
35 cial performance of these facilities, and shall include an anal-
36 ysis (by specific RUG classification) of the number and charac-
37 teristics of such facilities.

1 (e) HCFA STUDY OF CLASSIFICATION SYSTEMS FOR SNF
2 RESIDENTS.—

3 (1) STUDY.—The Secretary of Health and Human
4 Services shall conduct a study of the different systems for
5 categorizing patients in medicare skilled nursing facilities
6 in a manner that accounts for the relative resource utiliza-
7 tion of different patient types.

8 (2) REPORT.—Not later than January 1, 2005, the
9 Secretary shall submit to Congress a report on the study
10 conducted under subsection (a). Such report shall include
11 such recommendations regarding changes in law as may be
12 appropriate.

13 **SEC. 312. INCREASE IN NURSING COMPONENT OF PPS**
14 **FEDERAL RATE.**

15 (a) IN GENERAL.—The Secretary of Health and Human
16 Services shall increase by 16.66 percent the nursing component
17 of the case-mix adjusted Federal prospective payment rate
18 specified in Tables 3 and 4 of the final rule published in the
19 Federal Register by the Health Care Financing Administration
20 on July 31, 2000 (65 Fed. Reg. 46770), effective for services
21 furnished on or after April 1, 2001, and before October 1,
22 2002.

23 (b) GAO AUDIT OF NURSING STAFF RATIOS.—

24 (1) AUDIT.—The Comptroller General of the United
25 States shall conduct an audit of nursing staffing ratios in
26 a representative sample of medicare skilled nursing facili-
27 ties. Such sample shall cover selected States and shall in-
28 clude broad representation with respect to size, ownership,
29 location, and medicare volume. Such audit shall include an
30 examination of payroll records and medicaid cost reports of
31 individual facilities.

32 (2) REPORT.—Not later than August 1, 2002, the
33 Comptroller General shall submit to Congress a report on
34 the audits conducted under paragraph (1). Such report
35 shall include an assessment of the impact of the increased
36 payments under this subtitle on increased nursing staff ra-

1 tios and shall make recommendations as to whether in-
2 creased payments under subsection (a) should be continued.

3 **SEC. 313. APPLICATION OF SNF CONSOLIDATED BILL-**
4 **ING REQUIREMENT LIMITED TO PART A**
5 **COVERED STAYS.**

6 (a) IN GENERAL.—Section 1862(a)(18) (42 U.S.C.
7 1395y(a)(18)) is amended by striking “or of a part of a facility
8 that includes a skilled nursing facility (as determined under
9 regulations),” and inserting “during a period in which the resi-
10 dent is provided covered post-hospital extended care services
11 (or, for services described in section 1861(s)(2)(D), which are
12 furnished to such an individual without regard to such pe-
13 riod),”.

14 (b) CONFORMING AMENDMENTS.—(1) Section
15 1842(b)(6)(E) (42 U.S.C. 1395u(b)(6)(E)) is amended—

16 (A) by inserting “by, or under arrangements made by,
17 a skilled nursing facility” after “furnished”;

18 (B) by striking “or of a part of a facility that includes
19 a skilled nursing facility (as determined under regula-
20 tions)”;

21 (C) by striking “(without regard to whether or not the
22 item or service was furnished by the facility, by others
23 under arrangement with them made by the facility, under
24 any other contracting or consulting arrangement, or other-
25 wise)”.

26 (2) Section 1842(t) (42 U.S.C. 1395u(t)) is amended by
27 striking “by a physician” and “or of a part of a facility that
28 includes a skilled nursing facility (as determined under regula-
29 tions),”.

30 (3) Section 1866(a)(1)(H)(ii)(I) (42 U.S.C.
31 1395cc(a)(1)(H)(ii)(I)) is amended by inserting after “who is
32 a resident of the skilled nursing facility” the following: “during
33 a period in which the resident is provided covered post-hospital
34 extended care services (or, for services described in section
35 1861(s)(2)(D), that are furnished to such an individual without
36 regard to such period)”.

1 (c) EFFECTIVE DATE.—The amendments made by sub-
2 sections (a) and (b) apply to services furnished on or after Jan-
3 uary 1, 2001.

4 (d) OVERSIGHT.—The Secretary of Health and Human
5 Services, through the Office of the Inspector General in the De-
6 partment of Health and Human Services or otherwise, shall
7 monitor payments made under part B of the title XVIII of the
8 Social Security Act for items and services furnished to resi-
9 dents of skilled nursing facilities during a time in which the
10 residents are not being provided medicare covered post-hospital
11 extended care services to ensure that there is not duplicate bill-
12 ing for services or excessive services provided.

13 **SEC. 314. ADJUSTMENT OF REHABILITATION RUGS TO**
14 **CORRECT ANOMALY IN PAYMENT RATES.**

15 (a) ADJUSTMENT FOR REHABILITATION RUGS.—

16 (1) IN GENERAL.—For purposes of computing pay-
17 ments for covered skilled nursing facility services under
18 paragraph (1) of section 1888(e) of the Social Security Act
19 (42 U.S.C. 1395yy(e)) for such services furnished on or
20 after April 1, 2001, and before the date described in sec-
21 tion 101(c)(2) of BBRA (113 Stat. 1501A–324), the Sec-
22 retary of Health and Human Services shall increase by 6.7
23 percent the adjusted Federal per diem rate otherwise deter-
24 mined under paragraph (4) of such section (but for this
25 section) for covered skilled nursing facility services for
26 RUG–III rehabilitation groups described in paragraph (2)
27 furnished to an individual during the period in which such
28 individual is classified in such a RUG–III category.

29 (2) REHABILITATION GROUPS DESCRIBED.—The
30 RUG–III rehabilitation groups for which the adjustment
31 described in paragraph (1) applies are RUC, RUB, RUA,
32 RVC, RVB, RVA, RHC, RHB, RHA, RMC, RMB, RMA,
33 RLB, and RLA, as specified in Tables 3 and 4 of the final
34 rule published in the Federal Register by the Health Care
35 Financing Administration on July 31, 2000 (65 Fed. Reg.
36 46770).

1 (b) CORRECTION WITH RESPECT TO REHABILITATION
2 RUGs.—

3 (1) IN GENERAL.—Section 101(b) of BBRA (113
4 Stat. 1501A-324) is amended by striking “CA1, RHC,
5 RMC, and RMB” and inserting “and CA1”.

6 (2) EFFECTIVE DATE.—The amendment made by
7 paragraph (1) applies to services furnished on or after
8 April 1, 2001.

9 (c) REVIEW BY OFFICE OF INSPECTOR GENERAL.—The
10 Inspector General of the Department of Health and Human
11 Services shall review the medicare payment structure for serv-
12 ices classified within rehabilitation resource utilization groups
13 (RUGs) (as in effect after the date of the enactment of the
14 BBRA) to assess whether payment incentives exist for the de-
15 livery of inadequate care. Not later than October 1, 2001, the
16 Inspector General shall submit to Congress a report on such re-
17 view.

18 **SEC. 315. ESTABLISHMENT OF PROCESS FOR GEO-**
19 **GRAPHIC RECLASSIFICATION.**

20 (a) IN GENERAL.—The Secretary of Health and Human
21 Services may establish a procedure for the geographic reclassi-
22 fication of a skilled nursing facility for purposes of payment for
23 covered skilled nursing facility services under the prospective
24 payment system established under section 1888(e) of the Social
25 Security Act (42 U.S.C. 1395yy(e)). Such procedure may be
26 based upon the method for geographic reclassifications for in-
27 patient hospitals established under section 1886(d)(10) of the
28 Social Security Act (42 U.S.C. 1395ww(d)(10)).

29 (b) REQUIREMENT FOR SKILLED NURSING FACILITY
30 WAGE DATA.—In no case may the Secretary implement the
31 procedure under subsection (a) before such time as the Sec-
32 retary has collected data necessary to establish an area wage
33 index for skilled nursing facilities based on wage data from
34 such facilities.

Subtitle C—Hospice Care

SEC. 321. FULL MARKET BASKET INCREASE FOR 2001.

(a) IN GENERAL.—Section 1814(i)(1)(C)(ii) (42 U.S.C. 1395f(i)(1)(C)(ii)) is amended—

(1) by redesignating subclause (VII) as subclause (IX);

(2) in subclause (VI)—

(A) by striking “through 2002” and inserting “through 2000”; and

(B) by striking “and” at the end; and

(3) by inserting after subclause (VI) the following new subclauses:

“(VII) for fiscal year 2001, the market basket percentage increase for the fiscal year;

“(VIII) for fiscal year 2002, the market basket percentage increase for the fiscal year minus 0.25 percentage points; and”.

(b) TRANSITION DURING FISCAL YEAR 2001.—Notwithstanding the amendments made by subsection (a), for purposes of making payments for hospice care under section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) for fiscal year 2001, the payment rates referred to in paragraph (1)(C) of such section—

(1) for the period beginning on October 1, 2000, and ending on March 31, 2001, shall be the rate determined in accordance with the law as in effect on the day before the date of the enactment of this Act; and

(2) for the period beginning on April 1, 2001, and ending on September 30, 2001, shall be the rate that would have been determined under paragraph (1) if “plus 1.0 percentage points” were substituted for “minus 1.0 percentage points” under paragraph (1)(C)(ii)(VI) of such section for fiscal year 2001.

(c) CONFORMING AMENDMENTS TO BBRA.—

(1) IN GENERAL.—Section 131 of BBRA (113 Stat. 1501A–333) is repealed.

1 (2) EFFECTIVE DATE.—The amendment made by
2 paragraph (1) shall take effect as if included in the enact-
3 ment of BBRA.

4 (d) TECHNICAL AMENDMENT.—Section 1814(a)(7)(A)(ii)
5 (42 U.S.C. 1395f(a)(7)(A)(ii)) is amended by striking the pe-
6 riod at the end and inserting a semicolon.

7 **SEC. 322. CLARIFICATION OF PHYSICIAN CERTIFI-**
8 **CATION.**

9 (a) CERTIFICATION BASED ON NORMAL COURSE OF ILL-
10 NESS.—

11 (1) IN GENERAL.—Section 1814(a) (42 U.S.C.
12 1395f(a)) is amended by adding at the end the following
13 new sentence: “The certification regarding terminal illness
14 of an individual under paragraph (7) shall be based on the
15 physician’s or medical director’s clinical judgment regard-
16 ing the normal course of the individual’s illness.”.

17 (2) EFFECTIVE DATE.—The amendment made by
18 paragraph (1) applies to certifications made on or after the
19 date of the enactment of this Act.

20 (b) STUDY AND REPORT ON PHYSICIAN CERTIFICATION
21 REQUIREMENT FOR HOSPICE BENEFITS.—

22 (1) STUDY.—The Secretary of Health and Human
23 Services shall conduct a study to examine the appropriate-
24 ness of the certification regarding terminal illness of an in-
25 dividual under section 1814(a)(7) of the Social Security
26 Act (42 U.S.C. 1395f(a)(7)) that is required in order for
27 such individual to receive hospice benefits under the medi-
28 care program under title XVIII of such Act. In conducting
29 such study, the Secretary shall take into account the effect
30 of the amendment made by subsection (a).

31 (2) REPORT.—Not later than 2 years after the date of
32 the enactment of this Act, the Secretary of Health and
33 Human Services shall submit to Congress a report on the
34 study conducted under paragraph (1), together with any
35 recommendations for legislation that the Secretary deems
36 appropriate.

1 **SEC. 323. MEDPAC REPORT ON ACCESS TO, AND USE OF,**
2 **HOSPICE BENEFIT.**

3 (a) IN GENERAL.—The Medicare Payment Advisory Com-
4 mission shall conduct a study to examine the factors affecting
5 the use of hospice benefits under the medicare program under
6 title XVIII of the Social Security Act, including a delay in the
7 time (relative to death) of entry into a hospice program, and
8 differences in such use between urban and rural hospice pro-
9 grams and based upon the presenting condition of the patient.

10 (b) REPORT.—Not later than 18 months after the date of
11 the enactment of this Act, the Commission shall submit to Con-
12 gress a report on the study conducted under subsection (a), to-
13 gether with any recommendations for legislation that the Com-
14 mission deems appropriate.

15 **Subtitle D—Other Provisions**

16 **SEC. 331. RELIEF FROM MEDICARE PART A LATE EN-**
17 **ROLLMENT PENALTY FOR GROUP BUY-IN**
18 **FOR STATE AND LOCAL RETIREES.**

19 (a) IN GENERAL.—Section 1818 (42 U.S.C. 1395i-2) is
20 amended—

21 (1) in subsection (c)(6), by inserting before the semi-
22 colon at the end the following: “and shall be subject to re-
23 duction in accordance with subsection (d)(6)”;

24 (2) by adding at the end of subsection (d) the fol-
25 lowing new paragraph:

26 “(6)(A) In the case where a State, a political subdivision
27 of a State, or an agency or instrumentality of a State or polit-
28 ical subdivision thereof determines to pay, for the life of each
29 individual, the monthly premiums due under paragraph (1) on
30 behalf of each of the individuals in a qualified State or local
31 government retiree group who meets the conditions of sub-
32 section (a), the amount of any increase otherwise applicable
33 under section 1839(b) (as applied and modified by subsection
34 (c)(6) of this section) with respect to the monthly premium for
35 benefits under this part for an individual who is a member of
36 such group shall be reduced by the total amount of taxes paid
37 under section 3101(b) of the Internal Revenue Code of 1986

1 by such individual and under section 3111(b) by the employers
2 of such individual on behalf of such individual with respect to
3 employment (as defined in section 3121(b) of such Code).

4 “(B) For purposes of this paragraph, the term ‘qualified
5 State or local government retiree group’ means all of the indi-
6 viduals who retire prior to a specified date that is before Janu-
7 ary 1, 2002, from employment in 1 or more occupations or
8 other broad classes of employees of—

9 “(i) the State;

10 “(ii) a political subdivision of the State; or

11 “(iii) an agency or instrumentality of the State or po-
12 litical subdivision of the State.”.

13 (b) EFFECTIVE DATE.—The amendments made by sub-
14 section (a) apply to premiums for months beginning with July
15 1, 2001.

16 **SEC. 332. POSTING OF INFORMATION ON NURSING FA-**
17 **CILITY STAFFING.**

18 (a) MEDICARE.—Section 1819(b) (42 U.S.C. 1395i–3(b))
19 is amended by adding at the end the following new paragraph:

20 “(8) INFORMATION ON NURSE STAFFING.—

21 “(A) IN GENERAL.—A skilled nursing facility shall
22 post daily for each shift the current number of licensed
23 and unlicensed nursing staff directly responsible for
24 resident care in the facility. The information shall be
25 displayed in a uniform manner (as specified by the Sec-
26 retary) and in a clearly visible place.

27 “(B) PUBLICATION OF DATA.—A skilled nursing
28 facility shall, upon request, make available to the public
29 the nursing staff data described in subparagraph (A).”.

30 (b) MEDICAID.—Section 1919(b) (42 U.S.C. 1395r(b)) is
31 amended by adding at the end the following new paragraph:

32 “(8) INFORMATION ON NURSE STAFFING.—

33 “(A) IN GENERAL.—A nursing facility shall post
34 daily for each shift the current number of licensed and
35 unlicensed nursing staff directly responsible for resi-
36 dent care in the facility. The information shall be dis-

1 played in a uniform manner (as specified by the Sec-
2 retary) and in a clearly visible place.

3 “(B) PUBLICATION OF DATA.—A nursing facility
4 shall, upon request, make available to the public the
5 nursing staff data described in subparagraph (A).”.

6 **TITLE IV—PROVISIONS RELATING**
7 **TO PART B**
8 **Subtitle A—Hospital Outpatient**
9 **Services**

10 **SEC. 401. REVISION OF HOSPITAL OUTPATIENT PPS**
11 **PAYMENT UPDATE.**

12 (a) IN GENERAL.—Section 1833(t)(3)(C)(iii) (42 U.S.C.
13 1395l(t)(3)(C)(iii)) is amended by striking “in each of 2000,
14 2001, and 2002” and inserting “in each of 2000 and 2002”.

15 (b) ADJUSTMENT FOR CASE MIX CHANGES.—

16 (1) IN GENERAL.—Section 1833(t)(3)(C) (42 U.S.C.
17 1395l(t)(3)(C)) is amended—

18 (A) by redesignating clause (iii) as clause (iv); and

19 (B) by inserting after clause (ii) the following new
20 clause:

21 “(iii) ADJUSTMENT FOR SERVICE MIX
22 CHANGES.—Insofar as the Secretary determines
23 that the adjustments for service mix under para-
24 graph (2) for a previous year (or estimates that
25 such adjustments for a future year) did (or are
26 likely to) result in a change in aggregate payments
27 under this subsection during the year that are a re-
28 sult of changes in the coding or classification of
29 covered OPD services that do not reflect real
30 changes in service mix, the Secretary may adjust
31 the conversion factor computed under this subpara-
32 graph for subsequent years so as to eliminate the
33 effect of such coding or classification changes.”.

34 (2) EFFECTIVE DATE.—The amendments made by
35 paragraph (1) shall take effect as if included in the enact-
36 ment of BBA.

1 **SEC. 402. CLARIFYING PROCESS AND STANDARDS FOR**
2 **DETERMINING ELIGIBILITY OF DEVICES FOR**
3 **PASS-THROUGH PAYMENTS UNDER HOS-**
4 **HITAL OUTPATIENT PPS.**

5 (a) IN GENERAL.—Section 1833(t)(6) (42 U.S.C.
6 1395l(t)(6)) is amended—

7 (1) by redesignating subparagraphs (C) and (D) as
8 subparagraphs (D) and (E), respectively; and

9 (2) by striking subparagraph (B) and inserting the fol-
10 lowing new subparagraphs:

11 “(B) USE OF CATEGORIES IN DETERMINING ELI-
12 GIBILITY OF A DEVICE FOR PASS-THROUGH PAY-
13 MENTS.—The following provisions apply for purposes of
14 determining whether a medical device qualifies for addi-
15 tional payments under clause (ii) or (iv) of subpara-
16 graph (A):

17 “(i) ESTABLISHMENT OF INITIAL CAT-
18 EGORIES.—The Secretary shall initially establish
19 under this clause categories of medical devices
20 based on type of device by April 1, 2001. Such cat-
21 egories shall be established in a manner such that
22 each medical device that meets the requirements of
23 clause (ii) or (iv) of subparagraph (A) as of as of
24 January 1, 2001, is included in such a category
25 and no such device is included in more than one
26 category. For purposes of the preceding sentence,
27 whether a medical device meets such requirements
28 as of such date shall be determined on the basis of
29 the program memoranda issued before such date or
30 if the Secretary determines the medical device
31 would have been included in the program memo-
32 randa but for the requirement of subparagraph
33 (A)(iv)(I). The categories may be established under
34 this clause by program memorandum or otherwise,
35 after consultation with groups representing hos-
36 pitals, manufacturers of medical devices, and other
37 affected parties.

65

1 “(ii) ESTABLISHING CRITERIA FOR ADDI-
2 TIONAL CATEGORIES.—

3 “(I) IN GENERAL.—The Secretary shall
4 establish criteria that will be used for creation
5 of additional categories (other than those estab-
6 lished under clause (i)) through rulemaking
7 (which may include use of an interim final rule
8 with comment period).

9 “(II) STANDARD.—Such categories shall
10 be established under this clause in a manner
11 such that no medical device is described by
12 more than one category. Such criteria shall in-
13 clude a test of whether the average cost of de-
14 vices that would be included in a category and
15 are in use at the time the category is estab-
16 lished is not insignificant, as described in sub-
17 paragraph (A)(iv)(II).

18 “(III) DEADLINE.—Criteria shall first be
19 established under this clause by July 1, 2001.
20 The Secretary may establish in compelling cir-
21 cumstances categories under this clause before
22 the date such criteria are established.

23 “(IV) ADDING CATEGORIES.—The Sec-
24 retary shall promptly establish a new category
25 of medical devices under this clause for any
26 medical device that meets the requirements of
27 subparagraph (A)(iv) and for which none of the
28 categories in effect (or that were previously in
29 effect) is appropriate.

30 “(iii) PERIOD FOR WHICH CATEGORY IS IN EF-
31 FECT.—A category of medical devices established
32 under clause (i) or clause (ii) shall be in effect for
33 a period of at least 2 years, but not more than 3
34 years, that begins—

35 “(I) in the case of a category established
36 under clause (i), on the first date on which
37 payment was made under this paragraph for

66

1 any device described by such category (includ-
2 ing payments made during the period before
3 April 1, 2001); and

4 “(II) in the case of any other category, on
5 the first date on which payment is made under
6 this paragraph for any medical device that is
7 described by such category.

8 “(iv) REQUIREMENTS TREATED AS MET.—A
9 medical device shall be treated as meeting the re-
10 quirements of subparagraph (A)(iv) if—

11 “(I) the device is described by a category
12 established and in effect under clause (i); or

13 “(II) the device is described by a category
14 established and in effect under clause (ii) and
15 an application under section 515 of the Federal
16 Food, Drug, and Cosmetic Act has been ap-
17 proved with respect to the device, or the device
18 has been cleared for market under section
19 510(k) of such Act, or the device is exempt
20 from the requirements of section 510(k) of
21 such Act pursuant to subsection (l) or (m) of
22 section 510 of such Act or section 520(g) of
23 such Act.

24 Nothing in this clause shall be construed as requir-
25 ing an application or prior approval (other than
26 that described in subclause (II)) in order for a cov-
27 ered device to qualify for payment under this para-
28 graph.

29 “(C) LIMITED PERIOD OF PAYMENT.—

30 “(i) DRUGS AND BIOLOGICALS.—The payment
31 under this paragraph with respect to a drug or bio-
32 logical shall only apply during a period of at least
33 2 years, but not more than 3 years, that begins—

34 “(I) on the first date this subsection is im-
35 plemented in the case of a drug or biological
36 described in clause (i), (ii), or (iii) of subpara-
37 graph (A) and in the case of a drug or biologi-

1 cal described in subparagraph (A)(iv) and for
2 which payment under this part is made as an
3 outpatient hospital service before such first
4 date; or

5 “(II) in the case of a drug or biological de-
6 scribed in subparagraph (A)(iv) not described
7 in subclause (I), on the first date on which pay-
8 ment is made under this part for the drug or
9 biological as an outpatient hospital service.

10 “(ii) MEDICAL DEVICES.—Payment shall be
11 made under this paragraph with respect to a med-
12 ical device only if such device—

13 “(I) is described by a category of medical
14 devices established and in effect under subpara-
15 graph (B); and

16 “(II) is provided as part of a service (or
17 group of services) paid for under this sub-
18 section and provided during the period for
19 which such category is in effect under such
20 subparagraph.”.

21 (b) CONFORMING AMENDMENTS.—Section 1833(t) (42
22 U.S.C. 1395l(t)) is further amended—

23 (1) in paragraph (6)(A)(iv)(II), by striking “the cost
24 of the device, drug, or biological” and inserting “the cost
25 of the drug or biological or the average cost of the category
26 of devices”;

27 (2) in paragraph (6)(D) (as redesignated by sub-
28 section (a)(1)), by striking “subparagraph (D)(iii)” in the
29 matter preceding clause (i) and inserting “subparagraph
30 (E)(iii)”;

31 (3) in paragraph (12)(E), by striking “additional pay-
32 ments (consistent with paragraph (6)(B))” and inserting
33 “additional payments, the determination and deletion of
34 initial and new categories (consistent with subparagraphs
35 (B) and (C) of paragraph (6))”.

36 (c) EFFECTIVE DATE.—The amendments made by this
37 section take effect on the date of the enactment of this Act.

1 (d) TRANSITION.—

2 (1) IN GENERAL.—In the case of a medical device pro-
3 vided as part of a service (or group of services) furnished
4 during the period before initial categories are implemented
5 under subparagraph (B)(i) of section 1833(t)(6) of the So-
6 cial Security Act (as amended by subsection (a)), payment
7 shall be made for such device under such section in accord-
8 ance with the provisions in effect before the date of the en-
9 actment of this Act, except that, beginning on the date that
10 is 30 days after the date of the enactment of this Act, pay-
11 ment shall also be made for such a device that is not in-
12 cluded in a program memorandum described in such sub-
13 subparagraph if the Secretary of Health and Human Services
14 determines that the device is likely to be described by such
15 an initial category or would have been included in such pro-
16 gram memoranda but for the requirement of subparagraph
17 (A)(iv)(I) of that section.

18 (2) APPLICATION OF CURRENT PROCESS.—Notwith-
19 standing any other provision of law, the Secretary shall
20 continue to accept applications with respect to medical de-
21 vices under the process established pursuant to paragraph
22 (6) of section 1833(t) of the Social Security Act (as in ef-
23 fect on the day before the date of the enactment of this
24 Act) through December 1, 2000, and any device—

25 (A) with respect to which an application was sub-
26 mitted (pursuant to such process) on or before such
27 date; and

28 (B) that meets the requirements of clause (ii) or
29 (iv) of subparagraph (A) of such paragraph (as deter-
30 mined pursuant to such process),

31 shall be treated as a device with respect to which an initial
32 category is required to be established under subparagraph
33 (B)(i) of such paragraph (as amended by subsection
34 (a)(2)).

1 **SEC. 403. APPLICATION OF OPD PPS TRANSITIONAL**
2 **CORRIDOR PAYMENTS TO CERTAIN HOS-**
3 **PITALS THAT DID NOT SUBMIT A 1996 COST**
4 **REPORT.**

5 (a) IN GENERAL.—Section 1833(t)(7)(F)(ii)(I) (42 U.S.C.
6 1395l(t)(7)(F)(ii)(I)) is amended by inserting “(or in the case
7 of a hospital that did not submit a cost report for such period,
8 during the first subsequent cost reporting period ending before
9 2001 for which the hospital submitted a cost report)” after
10 “1996”.

11 (b) EFFECTIVE DATE.—The amendment made by sub-
12 section (a) shall take effect as if included in the enactment of
13 BBRA.

14 **SEC. 404. APPLICATION OF RULES FOR DETERMINING**
15 **PROVIDER-BASED STATUS FOR CERTAIN EN-**
16 **TITIES.**

17 (a) GRANDFATHER.—Notwithstanding any other provision
18 of law, for purposes of making determinations of provider-based
19 status under title XVIII of the Social Security Act on or after
20 October 1, 2000, any facility or organization that is treated as
21 provider-based in relation to a hospital or critical access hos-
22 pital under such title as of October 1, 2000—

23 (1) shall continue to be treated as provider-based in
24 relation to such hospital or critical access hospital under
25 such title during the 2-year period beginning on October 1,
26 2000; and

27 (2) the requirements, limitations, and exclusions speci-
28 fied in paragraphs (d), (e), (f), and (h) of section 413.65
29 of title 42, Code of Federal Regulations shall not apply to
30 such facility or organization in relation to such hospital or
31 critical access hospital until after the end of such 2-year
32 period.

33 (b) TEMPORARY CRITERIA.—For purposes of title XVIII
34 of the Social Security Act—

35 (1) a facility or organization for which a determination
36 of provider-based status in relation to a hospital or critical
37 access hospital is requested on or after October 1, 2000,
38 and before October 1, 2002, may not be treated as not hav-

1 ing provider-based status in relation to such a hospital for
2 any period before a determination is made with respect to
3 such status pursuant to such request; and

4 (2) in making a determination with respect to such
5 status for any facility or organization in relationship to
6 such a hospital on or after October 1, 2000, the following
7 rules apply:

8 (A) The facility or organization shall be treated as
9 satisfying any requirements and standards for geo-
10 graphic location in relation to such a hospital if the fa-
11 cility or organization—

12 (i) satisfies the requirements of section
13 413.65(d)(7) of title 42, Code of Federal Regula-
14 tions; or

15 (ii) is located not more than 35 miles from the
16 main campus of the hospital or critical access hos-
17 pital.

18 (B) The facility or organization shall be treated as
19 satisfying any of the requirements and standards for
20 geographic location in relation to such a hospital if the
21 facility or organization is owned and operated by a hos-
22 pital or critical access hospital that—

23 (i) is owned or operated by a unit of State or
24 local government, is a public or private nonprofit
25 corporation that is formally granted governmental
26 powers by a unit of State or local government, or
27 is a private hospital that has a contract with a
28 State or local government that includes the oper-
29 ation of clinics located off the main campus of the
30 hospital to assure access in a well-defined service
31 area to health care services for low-income individ-
32 uals who are not entitled to benefits under title
33 XVIII (or medical assistance under a State plan
34 under title XIX) of such Act; and

35 (ii) has a disproportionate share adjustment
36 percentage (as determined under section
37 1886(d)(5)(F) of such Act (42 U.S.C.

1 1395ww(d)(5)(F))) greater than 11.75 percent or
2 is described in clause (i)(II) of such section.

3 (c) DEFINITIONS.—For purposes of this section, the terms
4 “hospital” and “critical access hospital” have the meanings
5 given such terms in subsections (e) and (mm)(1), respectively,
6 of section 1861 of the Social Security Act (42 U.S.C. 1395x).

7 **SEC. 405. TREATMENT OF CHILDREN’S HOSPITALS**
8 **UNDER PROSPECTIVE PAYMENT SYSTEM.**

9 (a) IN GENERAL.—Section 1833(t) (42 U.S.C. 1395l(t)) is
10 amended—

11 (1) in the heading of paragraph (7)(D)(ii), by insert-
12 ing “AND CHILDREN’S HOSPITALS” after “CANCER HOS-
13 PITALS”; and

14 (2) in paragraphs (7)(D)(ii) and (11), by striking
15 “section 1886(d)(1)(B)(v)” and inserting “clause (iii) or
16 (v) of section 1886(d)(1)(B)”.

17 (b) EFFECTIVE DATE.—The amendments made by sub-
18 section (a) apply as if included in the enactment of section 202
19 of BBRA (113 Stat. 1501A–342).

20 **SEC. 406. INCLUSION OF TEMPERATURE MONITORED**
21 **CRYOABLATION IN TRANSITIONAL PASS-**
22 **THROUGH FOR CERTAIN MEDICAL DEVICES,**
23 **DRUGS, AND BIOLOGICALS UNDER OPD PPS.**

24 (a) IN GENERAL.—Section 1833(t)(6)(A)(ii) (42 U.S.C.
25 1395l(t)(6)(A)(ii)) is amended by inserting “or temperature
26 monitored cryoablation” after “device of brachytherapy”.

27 (b) EFFECTIVE DATE.—The amendment made by sub-
28 section (a) applies to devices furnished on or after April 1,
29 2001.

30 **Subtitle B—Provisions Relating to**
31 **Physicians’ Services**

32 **SEC. 411. GAO STUDIES RELATING TO PHYSICIANS’**
33 **SERVICES.**

34 (a) STUDY OF SPECIALIST PHYSICIANS’ SERVICES FUR-
35 NISHED IN PHYSICIANS’ OFFICES AND HOSPITAL OUTPATIENT
36 DEPARTMENT SERVICES.—

1 (1) STUDY.—The Comptroller General of the United
2 States shall conduct a study to examine the appropriate-
3 ness of furnishing in physicians' offices specialist physi-
4 cians' services (such as gastrointestinal endoscopic physi-
5 cians' services) which are ordinarily furnished in hospital
6 outpatient departments. In conducting this study, the
7 Comptroller General shall—

8 (A) review available scientific and clinical evidence
9 about the safety of performing procedures in physi-
10 cians' offices and hospital outpatient departments;

11 (B) assess whether resource-based practice ex-
12 pense relative values established by the Secretary of
13 Health and Human Services under the medicare physi-
14 cian fee schedule under section 1848 of the Social Se-
15 curity Act (42 U.S.C. 1395w-4) for such specialist
16 physicians' services furnished in physicians' offices and
17 hospital outpatient departments create an incentive to
18 furnish such services in physicians' offices instead of
19 hospital outpatient departments; and

20 (C) assess the implications for access to care for
21 medicare beneficiaries if the medicare program were
22 not to cover such services in physicians' offices.

23 (2) REPORT.—Not later than July 1, 2001, the Comp-
24 troller General shall submit to Congress a report on such
25 study and include such recommendations as the Comp-
26 troller General determines to be appropriate.

27 (b) STUDY OF THE RESOURCE-BASED PRACTICE EX-
28 PENSE SYSTEM.—

29 (1) STUDY.—The Comptroller General of the United
30 States shall conduct a study on the refinements to the
31 practice expense relative value units during the transition
32 to a resource-based practice expense system for physician
33 payments under the medicare program under title XVIII of
34 the Social Security Act. Such study shall examine how the
35 Secretary of Health and Human Services has accepted and
36 used the practice expense data submitted under section 212
37 of BBRA (113 Stat. 1501A-350).

1 (2) REPORT.—Not later than July 1, 2001, the Comp-
 2 troller General shall submit to Congress a report on the
 3 study conducted under paragraph (1) together with rec-
 4 ommendations regarding—

5 (A) improvements in the process for acceptance
 6 and use of practice expense data under section 212 of
 7 BBRA;

8 (B) any change or adjustment that is appropriate
 9 to ensure full access to a spectrum of care for bene-
 10 ficiaries under the medicare program; and

11 (C) the appropriateness of payments to physicians.

12 **SEC. 412. PHYSICIAN GROUP PRACTICE DEMONSTRATION.**
 13

14 (a) IN GENERAL.—Title XVIII is amended by inserting
 15 after section 1866 the following new sections:

16 “DEMONSTRATION OF APPLICATION OF PHYSICIAN VOLUME
 17 INCREASES TO GROUP PRACTICES

18 “SEC. 1866A. (a) DEMONSTRATION PROGRAM AUTHOR-
 19 IZED.—

20 “(1) IN GENERAL.—The Secretary shall conduct dem-
 21 onstration projects to test and, if proven effective, expand
 22 the use of incentives to health care groups participating in
 23 the program under this title that—

24 “(A) encourage coordination of the care furnished
 25 to individuals under the programs under parts A and
 26 B by institutional and other providers, practitioners,
 27 and suppliers of health care items and services;

28 “(B) encourage investment in administrative
 29 structures and processes to ensure efficient service de-
 30 livery; and

31 “(C) reward physicians for improving health out-
 32 comes.

33 Such projects shall focus on the efficiencies of furnishing
 34 health care in a group-practice setting as compared to the
 35 efficiencies of furnishing health care in other health care
 36 delivery systems.

1 “(2) ADMINISTRATION BY CONTRACT.—Except as oth-
2 erwise specifically provided, the Secretary may administer
3 the program under this section in accordance with section
4 1866B.

5 “(3) DEFINITIONS.—For purposes of this section,
6 terms have the following meanings:

7 “(A) PHYSICIAN.—Except as the Secretary may
8 otherwise provide, the term ‘physician’ means any indi-
9 vidual who furnishes services which may be paid for as
10 physicians’ services under this title.

11 “(B) HEALTH CARE GROUP.—The term ‘health
12 care group’ means a group of physicians (as defined in
13 subparagraph (A)) organized at least in part for the
14 purpose of providing physicians’ services under this
15 title. As the Secretary finds appropriate, a health care
16 group may include a hospital and any other individual
17 or entity furnishing items or services for which pay-
18 ment may be made under this title that is affiliated
19 with the health care group under an arrangement
20 structured so that such individual or entity participates
21 in a demonstration under this section and will share in
22 any bonus earned under subsection (d).

23 “(b) ELIGIBILITY CRITERIA.—

24 “(1) IN GENERAL.—The Secretary is authorized to es-
25 tablish criteria for health care groups eligible to participate
26 in a demonstration under this section, including criteria re-
27 lating to numbers of health care professionals in, and of
28 patients served by, the group, scope of services provided,
29 and quality of care.

30 “(2) PAYMENT METHOD.—A health care group partici-
31 pating in the demonstration under this section shall agree
32 with respect to services furnished to beneficiaries within the
33 scope of the demonstration (as determined under sub-
34 section (c))—

35 “(A) to be paid on a fee-for-service basis; and

36 “(B) that payment with respect to all such serv-
37 ices furnished by members of the health care group to

1 such beneficiaries shall (where determined appropriate
2 by the Secretary) be made to a single entity.

3 “(3) DATA REPORTING.—A health care group partici-
4 pating in a demonstration under this section shall report to
5 the Secretary such data, at such times and in such format
6 as the Secretary requires, for purposes of monitoring and
7 evaluation of the demonstration under this section.

8 “(c) PATIENTS WITHIN SCOPE OF DEMONSTRATION.—

9 “(1) IN GENERAL.—The Secretary shall specify, in ac-
10 cordance with this subsection, the criteria for identifying
11 those patients of a health care group who shall be consid-
12 ered within the scope of the demonstration under this sec-
13 tion for purposes of application of subsection (d) and for
14 assessment of the effectiveness of the group in achieving
15 the objectives of this section.

16 “(2) OTHER CRITERIA.—The Secretary may establish
17 additional criteria for inclusion of beneficiaries within a
18 demonstration under this section, which may include fre-
19 quency of contact with physicians in the group or other fac-
20 tors or criteria that the Secretary finds to be appropriate.

21 “(3) NOTICE REQUIREMENTS.—In the case of each
22 beneficiary determined to be within the scope of a dem-
23 onstration under this section with respect to a specific
24 health care group, the Secretary shall ensure that such
25 beneficiary is notified of the incentives, and of any waivers
26 of coverage or payment rules, applicable to such group
27 under such demonstration.

28 “(d) INCENTIVES.—

29 “(1) PERFORMANCE TARGET.—The Secretary shall es-
30 tablish for each health care group participating in a dem-
31 onstration under this section—

32 “(A) a base expenditure amount, equal to the av-
33 erage total payments under parts A and B for patients
34 served by the health care group on a fee-for-service
35 basis in a base period determined by the Secretary; and

36 “(B) an annual per capita expenditure target for
37 patients determined to be within the scope of the dem-

1 under section 1876 (or a similar organization operating
2 under a demonstration project authority), an organiza-
3 tion with an agreement under section 1833(a)(1)(A), or
4 a PACE program under section 1894.

5 “(2) SECRETARY’S DISCRETION AS TO SCOPE OF PRO-
6 GRAM.—The Secretary may limit the implementation of the
7 demonstration program to—

8 “(A) a geographic area (or areas) that the Sec-
9 retary designates for purposes of the program, based
10 upon such criteria as the Secretary finds appropriate;

11 “(B) a subgroup (or subgroups) of beneficiaries or
12 individuals and entities furnishing items or services
13 (otherwise eligible to participate in the program), se-
14 lected on the basis of the number of such participants
15 that the Secretary finds consistent with the effective
16 and efficient implementation of the program;

17 “(C) an element (or elements) of the program that
18 the Secretary determines to be suitable for implementa-
19 tion; or

20 “(D) any combination of any of the limits de-
21 scribed in subparagraphs (A) through (C).

22 “(3) VOLUNTARY RECEIPT OF ITEMS AND SERV-
23 ICES.—Items and services shall be furnished to an indi-
24 vidual under the demonstration program only at the indi-
25 vidual’s election.

26 “(4) AGREEMENTS.—The Secretary is authorized to
27 enter into agreements with individuals and entities to fur-
28 nish health care items and services to beneficiaries under
29 the demonstration program.

30 “(5) PROGRAM STANDARDS AND CRITERIA.—The Sec-
31 retary shall establish performance standards for the dem-
32 onstration program including, as applicable, standards for
33 quality of health care items and services, cost-effectiveness,
34 beneficiary satisfaction, and such other factors as the Sec-
35 retary finds appropriate. The eligibility of individuals or en-
36 tities for the initial award, continuation, and renewal of
37 agreements to provide health care items and services under

1 the program shall be conditioned, at a minimum, on per-
2 formance that meets or exceeds such standards.

3 “(6) ADMINISTRATIVE REVIEW OF DECISIONS AFFECT-
4 ING INDIVIDUALS AND ENTITIES FURNISHING SERVICES.—
5 An individual or entity furnishing services under the dem-
6 onstration program shall be entitled to a review by the pro-
7 gram administrator (or, if the Secretary has not contracted
8 with a program administrator, by the Secretary) of a deci-
9 sion not to enter into, or to terminate, or not to renew, an
10 agreement with the entity to provide health care items or
11 services under the program.

12 “(7) SECRETARY’S REVIEW OF MARKETING MATE-
13 RIALS.—An agreement with an individual or entity fur-
14 nishing services under the demonstration program shall re-
15 quire the individual or entity to guarantee that it will not
16 distribute materials that market items or services under the
17 program without the Secretary’s prior review and approval.

18 “(8) PAYMENT IN FULL.—

19 “(A) IN GENERAL.—Except as provided in sub-
20 paragraph (B), an individual or entity receiving pay-
21 ment from the Secretary under a contract or agreement
22 under the demonstration program shall agree to accept
23 such payment as payment in full, and such payment
24 shall be in lieu of any payments to which the individual
25 or entity would otherwise be entitled under this title.

26 “(B) COLLECTION OF DEDUCTIBLES AND COIN-
27 SURANCE.—Such individual or entity may collect any
28 applicable deductible or coinsurance amount from a
29 beneficiary.

30 “(b) CONTRACTS FOR PROGRAM ADMINISTRATION.—

31 “(1) IN GENERAL.—The Secretary may administer the
32 demonstration program through a contract with a program
33 administrator in accordance with the provisions of this sub-
34 section.

35 “(2) SCOPE OF PROGRAM ADMINISTRATOR CON-
36 TRACTS.—The Secretary may enter into such contracts for

1 a limited geographic area, or on a regional or national
2 basis.

3 “(3) ELIGIBLE CONTRACTORS.—The Secretary may
4 contract for the administration of the program with—

5 “(A) an entity that, under a contract under sec-
6 tion 1816 or 1842, determines the amount of and
7 makes payments for health care items and services fur-
8 nished under this title; or

9 “(B) any other entity with substantial experience
10 in managing the type of program concerned.

11 “(4) CONTRACT AWARD, DURATION, AND RENEWAL.—

12 “(A) IN GENERAL.—A contract under this sub-
13 section shall be for an initial term of up to three years,
14 renewable for additional terms of up to three years.

15 “(B) NONCOMPETITIVE AWARD AND RENEWAL
16 FOR ENTITIES ADMINISTERING PART A OR PART B PAY-
17 MENTS.—The Secretary may enter or renew a contract
18 under this subsection with an entity described in para-
19 graph (3)(A) without regard to the requirements of sec-
20 tion 5 of title 41, United States Code.

21 “(5) APPLICABILITY OF FEDERAL ACQUISITION REGU-
22 LATION.—The Federal Acquisition Regulation shall apply
23 to program administration contracts under this subsection.

24 “(6) PERFORMANCE STANDARDS.—The Secretary shall
25 establish performance standards for the program adminis-
26 trator including, as applicable, standards for the quality
27 and cost-effectiveness of the program administered, and
28 such other factors as the Secretary finds appropriate. The
29 eligibility of entities for the initial award, continuation, and
30 renewal of program administration contracts shall be condi-
31 tioned, at a minimum, on performance that meets or ex-
32 ceeds such standards.

33 “(7) FUNCTIONS OF PROGRAM ADMINISTRATOR.—A
34 program administrator shall perform any or all of the fol-
35 lowing functions, as specified by the Secretary:

36 “(A) AGREEMENTS WITH ENTITIES FURNISHING
37 HEALTH CARE ITEMS AND SERVICES.—Determine the

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1 qualifications of entities seeking to enter or renew
2 agreements to provide services under the demonstration
3 program, and as appropriate enter or renew (or refuse
4 to enter or renew) such agreements on behalf of the
5 Secretary.

6 “(B) ESTABLISHMENT OF PAYMENT RATES.—Ne-
7 gotiate or otherwise establish, subject to the Secretary’s
8 approval, payment rates for covered health care items
9 and services.

10 “(C) PAYMENT OF CLAIMS OR FEES.—Administer
11 payments for health care items or services furnished
12 under the program.

13 “(D) PAYMENT OF BONUSES.—Using such guide-
14 lines as the Secretary shall establish, and subject to the
15 approval of the Secretary, make bonus payments as de-
16 scribed in subsection (c)(2)(A)(ii) to entities furnishing
17 items or services for which payment may be made
18 under the program.

19 “(E) OVERSIGHT.—Monitor the compliance of in-
20 dividuals and entities with agreements under the pro-
21 gram with the conditions of participation.

22 “(F) ADMINISTRATIVE REVIEW.—Conduct reviews
23 of adverse determinations specified in subsection (a)(6).

24 “(G) REVIEW OF MARKETING MATERIALS.—Con-
25 duct a review of marketing materials proposed by an
26 entity furnishing services under the program.

27 “(H) ADDITIONAL FUNCTIONS.—Perform such
28 other functions as the Secretary may specify.

29 “(8) LIMITATION OF LIABILITY.—The provisions of
30 section 1157(b) shall apply with respect to activities of con-
31 tractors and their officers, employees, and agents under a
32 contract under this subsection.

33 “(9) INFORMATION SHARING.—Notwithstanding sec-
34 tion 1106 and section 552a of title 5, United States Code,
35 the Secretary is authorized to disclose to an entity with a
36 program administration contract under this subsection such
37 information (including medical information) on individuals

1 receiving health care items and services under the program
2 as the entity may require to carry out its responsibilities
3 under the contract.

4 “(c) RULES APPLICABLE TO BOTH PROGRAM AGREE-
5 MENTS AND PROGRAM ADMINISTRATION CONTRACTS.—

6 “(1) RECORDS, REPORTS, AND AUDITS.—The Sec-
7 retary is authorized to require entities with agreements to
8 provide health care items or services under the demonstra-
9 tion program, and entities with program administration
10 contracts under subsection (b), to maintain adequate
11 records, to afford the Secretary access to such records (in-
12 cluding for audit purposes), and to furnish such reports
13 and other materials (including audited financial statements
14 and performance data) as the Secretary may require for
15 purposes of implementation, oversight, and evaluation of
16 the program and of individuals’ and entities’ effectiveness
17 in performance of such agreements or contracts.

18 “(2) BONUSES.—Notwithstanding any other provision
19 of law, but subject to subparagraph (B)(ii), the Secretary
20 may make bonus payments under the demonstration pro-
21 gram from the Federal Health Insurance Trust Fund and
22 the Federal Supplementary Medical Insurance Trust Fund
23 in amounts that do not exceed the amounts authorized
24 under the program in accordance with the following:

25 “(A) PAYMENTS TO PROGRAM ADMINISTRATORS.—
26 The Secretary may make bonus payments under the
27 program to program administrators.

28 “(B) PAYMENTS TO ENTITIES FURNISHING SERV-
29 ICES.—

30 “(i) IN GENERAL.—Subject to clause (ii), the
31 Secretary may make bonus payments to individuals
32 or entities furnishing items or services for which
33 payment may be made under the demonstration
34 program, or may authorize the program adminis-
35 trator to make such bonus payments in accordance
36 with such guidelines as the Secretary shall establish
37 and subject to the Secretary’s approval.

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1 “(ii) LIMITATIONS.—The Secretary may condi-
2 tion such payments on the achievement of such
3 standards related to efficiency, improvement in
4 processes or outcomes of care, or such other factors
5 as the Secretary determines to be appropriate.

6 “(3) ANTIDISCRIMINATION LIMITATION.—The Sec-
7 retary shall not enter into an agreement with an entity to
8 provide health care items or services under the demonstra-
9 tion program, or with an entity to administer the program,
10 unless such entity guarantees that it will not deny, limit,
11 or condition the coverage or provision of benefits under the
12 program, for individuals eligible to be enrolled under such
13 program, based on any health status-related factor de-
14 scribed in section 2702(a)(1) of the Public Health Service
15 Act.

16 “(d) LIMITATIONS ON JUDICIAL REVIEW.—The following
17 actions and determinations with respect to the demonstration
18 program shall not be subject to review by a judicial or adminis-
19 trative tribunal:

20 “(1) Limiting the implementation of the program
21 under subsection (a)(2).

22 “(2) Establishment of program participation standards
23 under subsection (a)(5) or the denial or termination of, or
24 refusal to renew, an agreement with an entity to provide
25 health care items and services under the program.

26 “(3) Establishment of program administration con-
27 tract performance standards under subsection (b)(6), the
28 refusal to renew a program administration contract, or the
29 noncompetitive award or renewal of a program administra-
30 tion contract under subsection (b)(4)(B).

31 “(5) Establishment of payment rates, through negotia-
32 tion or otherwise, under a program agreement or a pro-
33 gram administration contract.

34 “(6) A determination with respect to the program
35 (where specifically authorized by the program authority or
36 by subsection (c)(2))—

1 (2) review direct and indirect costs associated with the
2 current process incurred by the medicare program and
3 groups that retain independent contractor physicians;

4 (3) assess the effect on program integrity by the en-
5 rollment of groups that retain independent contractor hos-
6 pital-based physicians; and

7 (4) develop suggested procedures for the enrollment of
8 these groups.

9 (b) REPORT.—Not later than 1 year after the date of the
10 enactment of this Act, the Comptroller General shall submit to
11 Congress a report on the study conducted under subsection (a).

12 **Subtitle C—Other Services**

13 **SEC. 421. 1-YEAR EXTENSION OF MORATORIUM ON** 14 **THERAPY CAPS; REPORT ON STANDARDS** 15 **FOR SUPERVISION OF PHYSICAL THERAPY** 16 **ASSISTANTS.**

17 (a) IN GENERAL.—Section 1833(g)(4) (42 U.S.C.
18 1395l(g)(4)) is amended by striking “2000 and 2001.” and in-
19 serting “2000, 2001, and 2002.”.

20 (b) CONFORMING AMENDMENT TO CONTINUE FOCUSED
21 MEDICAL REVIEWS OF CLAIMS DURING MORATORIUM PE-
22 RIOD.—Section 221(a)(2) of BBRA (113 Stat. 1501A–351) is
23 amended by striking “(under the amendment made by para-
24 graph (1)(B))”.

25 (c) STUDY ON STANDARDS FOR SUPERVISION OF PHYS-
26 ICAL THERAPIST ASSISTANTS.—

27 (1) STUDY.—The Secretary of Health and Human
28 Services shall conduct a study of the implications—

29 (A) of eliminating the “in the room” supervision
30 requirement for medicare payment for services of phys-
31 ical therapy assistants who are supervised by physical
32 therapists; and

33 (B) of such requirement on the cap imposed under
34 section 1833(g) of the Social Security Act (42 U.S.C.
35 1395l(g)) on physical therapy services.

36 (2) REPORT.—Not later than 18 months after the
37 date of the enactment of this Act, the Secretary shall sub-

1 mit to Congress a report on the study conducted under
2 paragraph (1).

3 **SEC. 422. UPDATE IN RENAL DIALYSIS COMPOSITE**
4 **RATE.**

5 (a) UPDATE.—

6 (1) IN GENERAL.—The last sentence of section
7 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by strik-
8 ing “for such services furnished on or after January 1,
9 2001, by 1.2 percent” and inserting “for such services fur-
10 nished on or after January 1, 2001, by 2.4 percent”.

11 (2) PROHIBITION ON EXEMPTIONS.—

12 (A) IN GENERAL.—Subject to subparagraph (B),
13 the Secretary of Health and Human Services may not
14 provide for an exception under section 1881(b)(7) of
15 the Social Security Act (42 U.S.C. 1395rr(b)(7)) on or
16 after December 31, 2000.

17 (B) SPECIAL RULES FOR 2000.—

18 (i) IN GENERAL.—Any exemption rate under
19 such section 1881(b)(7) in effect on December 31,
20 2000, shall continue in effect so long as such rate
21 is greater than the composite rate as updated by
22 the amendment made by paragraph (1).

23 (ii) RESUBMISSION OF CERTAIN APPLICA-
24 TIONS.—In the case of an application for an ex-
25 emption rate under such section that was filed by
26 a facility during 2000 that was not approved by the
27 Secretary of Health and Human Services, the facil-
28 ity may submit an application for an exemption
29 rate for that year by not later than July 1, 2001.

30 (b) DEVELOPMENT OF ESRD MARKET BASKET.—

31 (1) DEVELOPMENT.—The Secretary of Health and
32 Human Services shall collect data and develop an ESRD
33 market basket whereby the Secretary can estimate, before
34 the beginning of a year, the percentage by which the costs
35 for the year of the mix of labor and nonlabor goods and
36 services included in the ESRD composite rate under section
37 1881(b)(7) of the Social Security Act (42 U.S.C.

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1 1395rr(b)(7)) will exceed the costs of such mix of goods
2 and services for the preceding year. In developing such
3 index, the Secretary may take into account measures of
4 changes in—

5 (A) technology used in furnishing dialysis services;

6 (B) the manner or method of furnishing dialysis
7 services; and

8 (C) the amounts by which the payments under
9 such section for all services billed by a facility for a
10 year exceed the aggregate allowable audited costs of
11 such services for such facility for such year.

12 (2) REPORT.—The Secretary of Health and Human
13 Services shall submit to Congress a report on the index de-
14 veloped under paragraph (1) no later than July 1, 2002,
15 and shall include in the report recommendations on the ap-
16 propriateness of an annual or periodic update mechanism
17 for renal dialysis services under the medicare program
18 under title XVIII of the Social Security Act based on such
19 index.

20 (c) INCLUSION OF ADDITIONAL SERVICES IN COMPOSITE
21 RATE.—

22 (1) DEVELOPMENT.—The Secretary of Health and
23 Human Services shall develop a system which includes, to
24 the maximum extent feasible, in the composite rate used
25 for payment under section 1881(b)(7) of the Social Secu-
26 rity Act (42 U.S.C. 1395rr(b)(7)), payment for clinical di-
27 agnostic laboratory tests and drugs (including drugs paid
28 under section 1881(b)(11)(B) of such Act (42 U.S.C.
29 1395rr(b)(11)(B)) that are routinely used in furnishing di-
30 alysis services to medicare beneficiaries but which are cur-
31 rently separately billable by renal dialysis facilities.

32 (2) REPORT.—The Secretary shall include, as part of
33 the report submitted under subsection (b)(2), a report on
34 the system developed under paragraph (1) and rec-
35 ommendations on the appropriateness of incorporating the
36 system into medicare payment for renal dialysis services.

37 (d) GAO STUDY ON ACCESS TO SERVICES.—

1 (1) STUDY.—The Comptroller General of the United
2 States shall study access of medicare beneficiaries to renal
3 dialysis services. Such study shall include whether there is
4 a sufficient supply of facilities to furnish needed renal di-
5 alysis services, whether medicare payment levels are appro-
6 priate, taking into account audited costs of facilities for all
7 services furnished, to ensure continued access to such serv-
8 ices, and improvements in access (and quality of care) that
9 may result in the increased use of long nightly and short
10 daily hemodialysis modalities.

11 (2) REPORT.—Not later than January 1, 2003, the
12 Comptroller General shall submit to Congress a report on
13 the study conducted under paragraph (1).

14 **SEC. 423. PAYMENT FOR AMBULANCE SERVICES.**

15 (a) RESTORATION OF FULL CPI INCREASE FOR 2001.—
16 Section 1834(l)(3) (42 U.S.C. 1395m(l)(3)) is amended by
17 striking “reduced in the case of 2001 and 2002” each place it
18 appears and inserting “reduced in the case of 2002”.

19 (b) MILEAGE PAYMENTS.—Section 1834(l)(2)(E) (42
20 U.S.C. 1395m(l)(2)(E)) is amended by inserting before the pe-
21 riod at the end the following: “, except that, beginning on the
22 date on which the Secretary implements such fee schedule, such
23 phase-in shall provide for full payment of any national mileage
24 rate for ambulance services provided by suppliers that are paid
25 by carriers in any of the 50 States where payment by a carrier
26 for such services for all such suppliers in such State did not,
27 prior to the implementation of the fee schedule, include a sepa-
28 rate amount for all mileage within the county from which the
29 beneficiary is transported”.

30 (c) EFFECTIVE DATE.—The amendment made by sub-
31 section (a) applies to services furnished on or after the date on
32 which the Secretary of Health and Human Services implements
33 the fee schedule under section 1834(l) of the Social Security
34 Act (42 U.S.C. 1395m(l)).

35 **SEC. 424. AMBULATORY SURGICAL CENTERS.**

36 (a) DELAY IN IMPLEMENTATION OF PROSPECTIVE PAY-
37 MENT SYSTEM.—The Secretary of Health and Human Services

1 may not implement a revised prospective payment system for
2 services of ambulatory surgical facilities under section 1833(i)
3 of the Social Security Act (42 U.S.C. 1395l(i)) before January
4 1, 2002.

5 (b) EXTENDING PHASE-IN TO 4 YEARS.—Section 226 of
6 the BBRA (113 Stat. 1501A–354) is amended by striking
7 paragraphs (1) and (2) and inserting the following:

8 “(1) in the first year of its implementation, only a pro-
9 portion (specified by the Secretary and not to exceed $\frac{1}{4}$)
10 of the payment for such services shall be made in accord-
11 ance with such system and the remainder shall be made in
12 accordance with current regulations; and

13 “(2) in each of the following 2 years a proportion
14 (specified by the Secretary and not to exceed $\frac{1}{2}$, and $\frac{3}{4}$,
15 respectively) of the payment for such services shall be made
16 under such system and the remainder shall be made in ac-
17 cordance with current regulations.”.

18 (c) DEADLINE FOR USE OF 1999 OR LATER COST SUR-
19 VEYS.—Section 226 of BBRA (113 Stat. 1501A–354) is
20 amended by adding at the end the following:

21 “By not later than January 1, 2003, the Secretary shall incor-
22 porate data from a 1999 medicare cost survey or a subsequent
23 cost survey for purposes of implementing or revising such sys-
24 tem.”.

25 **SEC. 425. FULL UPDATE FOR DURABLE MEDICAL EQUIP-**
26 **MENT.**

27 (a) IN GENERAL.—Section 1834(a)(14) (42 U.S.C.
28 1395m(a)(14)) is amended—

29 (1) by redesignating subparagraph (D) as subpara-
30 graph (F);

31 (2) in subparagraph (C)—

32 (A) by striking “through 2002” and inserting
33 “through 2000”; and

34 (B) by striking “and” at the end; and

35 (3) by inserting after subparagraph (C) the following
36 new subparagraphs:

1 “(D) for 2001, the percentage increase in the Con-
2 sumer Price Index for all urban consumers (U.S. city
3 average) for the 12-month period ending with June
4 2000;

5 “(E) for 2002, 0 percentage points; and”.

6 (b) CONFORMING AMENDMENTS TO BBRA.—Subsection
7 (a) of section 228 of BBRA (113 Stat. 1501A–356) is
8 amended—

9 (1) in the matter preceding paragraph (1), by striking
10 “for such items”;

11 (2) in paragraph (1), by inserting “oxygen and oxygen
12 equipment for” after “(1)”; and

13 (3) in paragraph (2), by inserting “all such covered
14 items for” after “(2)”.

15 (c) EFFECTIVE DATE.—The amendments made by sub-
16 section (b) shall take effect as if included in the enactment of
17 BBRA.

18 **SEC. 426. FULL UPDATE FOR ORTHOTICS AND PROS-**
19 **THETICS.**

20 Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is
21 amended—

22 (1) by redesignating clause (vi) as clause (viii);

23 (2) in clause (v)—

24 (A) by striking “through 2002” and inserting
25 “through 2000”; and

26 (B) by striking “and” at the end; and

27 (3) by inserting after clause (v) the following new
28 clause:

29 “(vi) for 2001, the percentage increase in the
30 consumer price index for all urban consumers (U.S.
31 city average) for the 12-month period ending with
32 June 2000;

33 “(vii) for 2002, 1 percent; and”.

1 **SEC. 427. ESTABLISHMENT OF SPECIAL PAYMENT PRO-**
2 **VISIONS AND REQUIREMENTS FOR PROS-**
3 **THETICS AND CERTAIN CUSTOM FAB-**
4 **RICATED ORTHOTIC ITEMS.**

5 (a) IN GENERAL.—Section 1834(h)(1) (42 U.S.C.
6 1395m(h)(1)) is amended by adding at the end the following:

7 “(F) SPECIAL PAYMENT RULES FOR CERTAIN
8 PROSTHETICS AND CUSTOM FABRICATED ORTHOTICS.—

9 “(i) IN GENERAL.—No payment shall be made
10 under this subsection for an item of custom fab-
11 ricated orthotics described in clause (ii) or for an
12 item of prosthetics unless such item is—

13 “(I) furnished by a qualified practitioner;
14 and

15 “(II) fabricated by a qualified practitioner
16 or a qualified supplier at a facility that meets
17 such criteria as the Secretary determines ap-
18 propriate.

19 “(ii) DESCRIPTION OF CUSTOM FABRICATED
20 ITEM.—

21 “(I) IN GENERAL.—An item described in
22 this clause is an item of custom fabricated
23 orthotics that requires education, training, and
24 experience to custom fabricate and that is in-
25 cluded in a list established by the Secretary in
26 subclause (II). Such an item does not include
27 shoes and shoe inserts.

28 “(II) LIST OF ITEMS.—The Secretary, in
29 consultation with appropriate experts in
30 orthotics (including national organizations rep-
31 resenting manufacturers of orthotics), shall es-
32 tablish and update as appropriate a list of
33 items to which this subparagraph applies. No
34 item may be included in such list unless the
35 item is individually fabricated for the patient
36 over a positive model of the patient.

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1 “(iii) QUALIFIED PRACTITIONER DEFINED.—
2 In this subparagraph, the term ‘qualified practi-
3 tioner’ means a physician or other individual who—

4 “(I) is a qualified physical therapist or a
5 qualified occupational therapist;

6 “(II) in the case of a State that provides
7 for the licensing of orthotics and prosthetics, is
8 licensed in orthotics or prosthetics by the State
9 in which the item is supplied; or

10 “(III) in the case of a State that does not
11 provide for the licensing of orthotics and pros-
12 thetics, is specifically trained and educated to
13 provide or manage the provision of prosthetics
14 and custom-designed or fabricated orthotics,
15 and is certified by the American Board for Cer-
16 tification in Orthotics and Prosthetics, Inc. or
17 by the Board for Orthotist/Prosthetist Certifi-
18 cation, or is credentialed and approved by a
19 program that the Secretary determines, in con-
20 sultation with appropriate experts in orthotics
21 and prosthetics, has training and education
22 standards that are necessary to provide such
23 prosthetics and orthotics.

24 “(iv) QUALIFIED SUPPLIER DEFINED.—In this
25 subparagraph, the term ‘qualified supplier’ means
26 any entity that is accredited by the American
27 Board for Certification in Orthotics and Pros-
28 thetics, Inc. or by the Board for Orthotist/Pros-
29 thetist Certification, or accredited and approved by
30 a program that the Secretary determines has ac-
31 creditation and approval standards that are essen-
32 tially equivalent to those of such Board.”.

33 (b) EFFECTIVE DATE.—Not later than 1 year after the
34 date of the enactment of this Act, the Secretary of Health and
35 Human Services shall promulgate revised regulations to carry
36 out the amendment made by subsection (a) using a negotiated

1 rulemaking process under subchapter III of chapter 5 of title
2 5, United States Code.

3 (c) GAO STUDY AND REPORT.—

4 (1) STUDY.—The Comptroller General of the United
5 States shall conduct a study on HCFA Ruling 96-1, issued
6 on September 1, 1996, with respect to distinguishing
7 orthotics from durable medical equipment under the medi-
8 care program under title XVIII of the Social Security Act.
9 The study shall assess the following matters:

10 (A) The compliance of the Secretary of Health and
11 Human Services with the Administrative Procedures
12 Act (under chapter 5 of title 5, United States Code) in
13 making such ruling.

14 (B) The potential impact of such ruling on the
15 health care furnished to medicare beneficiaries under
16 the medicare program, especially those beneficiaries
17 with degenerative musculoskeletal conditions.

18 (C) The potential for fraud and abuse under the
19 medicare program if payment were provided for
20 orthotics used as a component of durable medical
21 equipment only when made under the special payment
22 provision for certain prosthetics and custom fabricated
23 orthotics under section 1834(h)(1)(F) of the Social Se-
24 curity Act, as added by subsection (a) and furnished by
25 qualified practitioners under that section.

26 (D) The impact on payments under titles XVIII
27 and XIX of the Social Security Act if such ruling were
28 overturned.

29 (2) REPORT.—Not later than 6 months after the date
30 of the enactment of this Act, the Comptroller General shall
31 submit to Congress a report on the study conducted under
32 paragraph (1).

33 **SEC. 428. REPLACEMENT OF PROSTHETIC DEVICES AND**
34 **PARTS.**

35 (a) IN GENERAL.—Section 1834(h)(1) (42 U.S.C.
36 1395m(h)(1)), as amended by section 427(a), is further amend-
37 ed by adding at the end the following new subparagraph:

1 “(G) REPLACEMENT OF PROSTHETIC DEVICES
2 AND PARTS.—

3 “(i) IN GENERAL.—Payment shall be made for
4 the replacement of prosthetic devices which are ar-
5 tificial limbs, or for the replacement of any part of
6 such devices, without regard to continuous use or
7 useful lifetime restrictions if an ordering physician
8 determines that the provision of a replacement de-
9 vice, or a replacement part of such a device, is nec-
10 essary because of any of the following:

11 “(I) A change in the physiological condi-
12 tion of the patient.

13 “(II) An irreparable change in the condi-
14 tion of the device, or in a part of the device.

15 “(III) The condition of the device, or the
16 part of the device, requires repairs and the cost
17 of such repairs would be more than 60 percent
18 of the cost of a replacement device, or, as the
19 case may be, of the part being replaced.

20 “(ii) CONFIRMATION MAY BE REQUIRED IF RE-
21 PLACEMENT DEVICE OR PART IS LESS THAN 3
22 YEARS OLD.—If a physician determines that a re-
23 placement device, or a replacement part, is nec-
24 essary pursuant to clause (i)—

25 “(I) such determination shall be control-
26 ling; and

27 “(II) such replacement device or part shall
28 be deemed to be reasonable and necessary for
29 purposes of section 1862(a)(1)(A);

30 except that if the device, or part, being replaced is
31 less than 3 years old (calculated from the date on
32 which the beneficiary began to use the device or
33 part), the Secretary may also require confirmation
34 of necessity of the replacement device, or, as the
35 case may be, the replacement part.”.

36 (b) PREEMPTION OF RULE.—The provisions of section
37 1834(h)(1)(G) as added by subsection (a) shall supersede any

1 rule that as of the date of the enactment of this Act may have
2 applied a 5-year replacement rule with regard to prosthetic de-
3 vices.

4 (c) EFFECTIVE DATE.—The amendment made by sub-
5 section (a) shall apply to items replaced on or after April 1,
6 2001.

7 **SEC. 429. REVISED PART B PAYMENT FOR DRUGS AND**
8 **BIOLOGICALS AND RELATED SERVICES.**

9 (a) RECOMMENDATIONS FOR REVISED PAYMENT METH-
10 ODOLOGY FOR DRUGS AND BIOLOGICALS.—

11 (1) STUDY.—

12 (A) IN GENERAL.—The Comptroller General of
13 the United States shall conduct a study on the reim-
14 bursement for drugs and biologicals under the current
15 medicare payment methodology (provided under section
16 1842(o) of the Social Security Act (42 U.S.C.
17 1395u(o)) and for related services under part B of title
18 XVIII of such Act. In the study, the Comptroller Gen-
19 eral shall—

20 (i) identify the average prices at which such
21 drugs and biologicals are acquired by physicians
22 and other suppliers;

23 (ii) quantify the difference between such aver-
24 age prices and the reimbursement amount under
25 such section; and

26 (iii) determine the extent to which (if any)
27 payment under such part is adequate to com-
28 pensate physicians, providers of services, or other
29 suppliers of such drugs and biologicals for costs in-
30 curred in the administration, handling, or storage
31 of such drugs or biologicals.

32 (B) CONSULTATION.—In conducting the study
33 under subparagraph (A), the Comptroller General shall
34 consult with physicians, providers of services, and sup-
35 pliers of drugs and biologicals under the medicare pro-
36 gram under title XVIII of such Act, as well as other
37 organizations involved in the distribution of such drugs

1 and biologicals to such physicians, providers of services,
2 and suppliers.

3 (2) REPORT.—Not later than 9 months after the date
4 of the enactment of this Act, the Comptroller General shall
5 submit to Congress and to the Secretary of Health and
6 Human Services a report on the study conducted under
7 this subsection, and shall include in such report rec-
8 ommendations for revised payment methodologies described
9 in paragraph (3).

10 (3) RECOMMENDATIONS FOR REVISED PAYMENT
11 METHODOLOGIES.—

12 (A) IN GENERAL.—The Comptroller General shall
13 provide specific recommendations for revised payment
14 methodologies for reimbursement for drugs and
15 biologicals and for related services under the medicare
16 program. The Comptroller General may include in the
17 recommendations—

18 (i) proposals to make adjustments under sub-
19 section (c) of section 1848 of the Social Security
20 Act (42 U.S.C. 1395w-4) for the practice expense
21 component of the physician fee schedule under such
22 section for the costs incurred in the administration,
23 handling, or storage of certain categories of such
24 drugs and biologicals, if appropriate; and

25 (ii) proposals for new payments to providers of
26 services or suppliers for such costs, if appropriate.

27 (B) ENSURING PATIENT ACCESS TO CARE.—In
28 making recommendations under this paragraph, the
29 Comptroller General shall ensure that any proposed re-
30 vised payment methodology is designed to ensure that
31 medicare beneficiaries continue to have appropriate ac-
32 cess to health care services under the medicare pro-
33 gram.

34 (C) MATTERS CONSIDERED.—In making rec-
35 ommendations under this paragraph, the Comptroller
36 General shall consider—

1 (i) the method and amount of reimbursement
2 for similar drugs and biologicals made by large
3 group health plans;

4 (ii) as a result of any revised payment method-
5 ology, the potential for patients to receive inpatient
6 or outpatient hospital services in lieu of services in
7 a physician's office; and

8 (iii) the effect of any revised payment method-
9 ology on the delivery of drug therapies by hospital
10 outpatient departments.

11 (D) COORDINATION WITH BBRA STUDY.—In mak-
12 ing recommendations under this paragraph, the Comp-
13 troller General shall conclude and take into account the
14 results of the study provided for under section 213(a)
15 of BBRA (113 Stat. 1501A-350).

16 (b) IMPLEMENTATION OF NEW PAYMENT METHOD-
17 OLOGY.—

18 (1) IN GENERAL.—Notwithstanding any other provi-
19 sion of law, based on the recommendations contained in the
20 report under subsection (a), the Secretary of Health and
21 Human Services, subject to paragraph (2), shall revise the
22 payment methodology under section 1842(o) of the Social
23 Security Act (42 U.S.C. 1395u(o)) for drugs and
24 biologicals furnished under part B of the medicare pro-
25 gram. To the extent the Secretary determines appropriate,
26 the Secretary may provide for the adjustments to payments
27 amounts referred to in subsection (a)(3)(A)(i) or additional
28 payments referred to in subsection (a)(2)(A)(ii).

29 (2) LIMITATION.—In revising the payment method-
30 ology under paragraph (1), in no case may the estimated
31 aggregate payments for drugs and biologicals under the re-
32 vised system (including additional payments referred to in
33 subsection (a)(3)(A)(ii)) exceed the aggregate amount of
34 payment for such drugs and biologicals, as projected by the
35 Secretary, that would have been made under the payment
36 methodology in effect under such section 1842(o).

1 (c) TEMPORARY INJUNCTION AGAINST REDUCTIONS IN
2 PAYMENT RATES.—Notwithstanding any other provision of
3 law, the Administrator of the Health Care Financing Adminis-
4 tration may not directly or indirectly increase or decrease the
5 rates of reimbursement (in effect on September 1, 2000) for
6 drugs and biologicals under the current medicare payment
7 methodology (provided under section 1842(o) of such Act (42
8 U.S.C. 1395u(o)) until such time as the Secretary has reviewed
9 the report submitted under subsection (a)(2).

10 **SEC. 430. CONTRAST ENHANCED DIAGNOSTIC PROCE-**
11 **DURES UNDER HOSPITAL PROSPECTIVE**
12 **PAYMENT SYSTEM.**

13 (a) SEPARATE CLASSIFICATION.—Section 1833(t)(2) (42
14 U.S.C. 1395l(t)(2)) is amended—

15 (1) by striking “and” at the end of subparagraph (E);

16 (2) by striking the period at the end of subparagraph
17 (F) and inserting “; and”; and

18 (3) by inserting after subparagraph (F) the following
19 new subparagraph:

20 “(G) the Secretary shall create additional groups
21 of covered OPD services that classify separately those
22 procedures that utilize contrast media from those that
23 do not.”.

24 (b) CONFORMING AMENDMENT.—Section 1861(t)(1) (42
25 U.S.C. 1395x(t)(1)) is amended by inserting “(including con-
26 trast agents)” after “only such drugs”.

27 (c) EFFECTIVE DATE.—The amendments made by this
28 section apply to items and services furnished on or after Janu-
29 ary 1, 2001.

30 **SEC. 431. QUALIFICATIONS FOR COMMUNITY MENTAL**
31 **HEALTH CENTERS.**

32 (a) MEDICARE PROGRAM.—Section 1861(ff)(3)(B) (42
33 U.S.C. 1395x(ff)(3)(B)) is amended by striking “entity” and
34 all that follows and inserting the following: “entity that—

35 “(i)(I) provides the mental health services described in
36 section 1913(c)(1) of the Public Health Service Act; or

1 **SEC. 433. GAO STUDY ON COVERAGE OF SURGICAL**
2 **FIRST ASSISTING SERVICES OF CERTIFIED**
3 **REGISTERED NURSE FIRST ASSISTANTS.**

4 (a) STUDY.—The Comptroller General of the United
5 States shall conduct a study on the effect on the medicare pro-
6 gram under title XVIII of the Social Security Act and on medi-
7 care beneficiaries of coverage under the program of surgical
8 first assisting services of certified registered nurse first assist-
9 ants. The Comptroller General shall consider the following
10 when conducting the study:

11 (1) Any impact on the quality of care furnished to
12 medicare beneficiaries by reason of such coverage.

13 (2) Appropriate education and training requirements
14 for certified registered nurse first assistants who furnish
15 such first assisting services.

16 (3) Appropriate rates of payment under the program
17 to such certified registered nurse first assistants for fur-
18 nishing such services, taking into account the costs of com-
19 pensation, overhead, and supervision attributable to cer-
20 tified registered nurse first assistants.

21 (b) REPORT.—Not later than 1 year after the date of the
22 enactment of this Act, the Comptroller General shall submit to
23 Congress a report on the study conducted under subsection (a).

24 **SEC. 434. MEDPAC STUDY AND REPORT ON MEDICARE**
25 **REIMBURSEMENT FOR SERVICES PROVIDED**
26 **BY CERTAIN PROVIDERS.**

27 (a) STUDY.—The Medicare Payment Advisory Commission
28 shall conduct a study on the appropriateness of the current
29 payment rates under the medicare program under title XVIII
30 of the Social Security Act for services provided by a—

31 (1) certified nurse-midwife (as defined in subsection
32 (gg)(2) of section 1861 of such Act (42 U.S.C. 1395x);

33 (2) physician assistant (as defined in subsection
34 (aa)(5)(A) of such section);

35 (3) nurse practitioner (as defined in such subsection);
36 and

37 (4) clinical nurse specialist (as defined in subsection
38 (aa)(5)(B) of such section).

1 (b) REPORT.—Not later than 18 months after the date of
2 the enactment of this Act, the Commission shall submit to Con-
3 gress a report on the study conducted under subsection (a), to-
4 gether with any recommendations for legislation that the Com-
5 mission determines to be appropriate as a result of such study.

6 **SEC. 435. MEDPAC STUDY AND REPORT ON MEDICARE**
7 **COVERAGE OF SERVICES PROVIDED BY CER-**
8 **TAIN NONPHYSICIAN PROVIDERS.**

9 (a) STUDY.—

10 (1) IN GENERAL.—The Medicare Payment Advisory
11 Commission shall conduct a study to determine the appro-
12 priateness of providing coverage under the medicare pro-
13 gram under title XVIII of the Social Security Act for serv-
14 ices provided by a—

15 (A) surgical technologist;

16 (B) marriage counselor;

17 (C) marriage and family therapist;

18 (D) pastoral care counselor; and

19 (E) licensed professional counselor of mental
20 health.

21 (2) COSTS TO PROGRAM.—The study shall consider the
22 short-term and long-term benefits, and costs to the medi-
23 care program, of providing the coverage described in para-
24 graph (1).

25 (b) REPORT.—Not later than 18 months after the date of
26 the enactment of this Act, the Commission shall submit to Con-
27 gress a report on the study conducted under subsection (a), to-
28 gether with any recommendations for legislation that the Com-
29 mission determines to be appropriate as a result of such study.

30 **SEC. 436. GAO STUDY AND REPORT ON THE COSTS OF**
31 **EMERGENCY AND MEDICAL TRANSPOR-**
32 **TATION SERVICES.**

33 (a) STUDY.—The Comptroller General of the United
34 States shall conduct a study on the costs of providing emer-
35 gency and medical transportation services across the range of
36 acuity levels of conditions for which such transportation serv-
37 ices are provided.

1 (b) REPORT.—Not later than 18 months after the date of
2 the enactment of this Act, the Comptroller General shall submit
3 to Congress a report on the study conducted under subsection
4 (a), together with recommendations for any changes in method-
5 ology or payment level necessary to fairly compensate suppliers
6 of emergency and medical transportation services and to ensure
7 the access of beneficiaries under the medicare program under
8 title XVIII of the Social Security Act.

9 **SEC. 437. GAO STUDIES AND REPORTS ON MEDICARE**
10 **PAYMENTS.**

11 (a) GAO STUDY ON HCFA POST-PAYMENT AUDIT PROC-
12 ESS.—

13 (1) STUDY.—The Comptroller General of the United
14 States shall conduct a study on the post-payment audit
15 process under the medicare program under title XVIII of
16 the Social Security Act as such process applies to physi-
17 cians, including the proper level of resources that the
18 Health Care Financing Administration should devote to
19 educating physicians regarding—

20 (A) coding and billing;

21 (B) documentation requirements; and

22 (C) the calculation of overpayments.

23 (2) REPORT.—Not later than 18 months after the
24 date of the enactment of this Act, the Comptroller General
25 shall submit to Congress a report on the study conducted
26 under paragraph (1) together with specific recommenda-
27 tions for changes or improvements in the post-payment
28 audit process described in such paragraph.

29 (b) GAO STUDY ON ADMINISTRATION AND OVERSIGHT.—

30 (1) STUDY.—The Comptroller General of the United
31 States shall conduct a study on the aggregate effects of
32 regulatory, audit, oversight, and paperwork burdens on
33 physicians and other health care providers participating in
34 the medicare program under title XVIII of the Social Secu-
35 rity Act.

36 (2) REPORT.—Not later than 18 months after the
37 date of the enactment of this Act, the Comptroller General

1 shall submit to Congress a report on the study conducted
2 under paragraph (1) together with recommendations re-
3 garding any area in which—

4 (A) a reduction in paperwork, an ease of adminis-
5 tration, or an appropriate change in oversight and re-
6 view may be accomplished; or

7 (B) additional payments or education are needed
8 to assist physicians and other health care providers in
9 understanding and complying with any legal or regu-
10 latory requirements.

11 **SEC. 438. MEDPAC STUDY ON ACCESS TO OUTPATIENT**
12 **PAIN MANAGEMENT SERVICES.**

13 (a) STUDY.—The Medicare Payment Advisory Commission
14 shall conduct a study on the barriers to coverage and payment
15 for outpatient interventional pain medicine procedures under
16 the medicare program under title XVIII of the Social Security
17 Act. Such study shall examine—

18 (1) the specific barriers imposed under the medicare
19 program on the provision of pain management procedures
20 in hospital outpatient departments, ambulatory surgery
21 centers, and physicians' offices; and

22 (2) the consistency of medicare payment policies for
23 pain management procedures in those different settings.

24 (b) REPORT.—Not later than 1 year after the date of the
25 enactment of this Act, the Commission shall submit to Con-
26 gress a report on the study.

27 **TITLE V—PROVISIONS RELATING**
28 **TO PARTS A AND B**
29 **Subtitle A—Home Health Services**

30 **SEC. 501. 1-YEAR ADDITIONAL DELAY IN APPLICATION**
31 **OF 15 PERCENT REDUCTION ON PAYMENT**
32 **LIMITS FOR HOME HEALTH SERVICES.**

33 (a) IN GENERAL.—Section 1895(b)(3)(A)(i) (42 U.S.C.
34 1395fff(b)(3)(A)(i)) is amended—

35 (1) by redesignating subclause (II) as subclause (III);

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1 (2) in subclause (III), as redesignated, by striking
2 “described in subclause (I)” and inserting “described in
3 subclause (II)”; and

4 (3) by inserting after subclause (I) the following new
5 subclause:

6 “(II) For the 12-month period beginning
7 after the period described in subclause (I), such
8 amount (or amounts) shall be equal to the
9 amount (or amounts) determined under sub-
10 clause (I), updated under subparagraph (B).”.

11 (b) CHANGE IN REPORT.—Section 302(c) of BBRA (113
12 Stat. 1501A–360) is amended—

13 (1) by striking “Not later than” and all that follows
14 through “(42 U.S.C. 1395fff)” and inserting “Not later
15 than April 1, 2002”; and

16 (2) by striking “Secretary” and inserting “Comptroller
17 General of the United States”.

18 (c) CASE MIX ADJUSTMENT CORRECTIONS.—

19 (1) IN GENERAL.—Section 1895(b)(3)(B) (42 U.S.C.
20 1395fff(b)(3)(B)) is amended by adding at the end the fol-
21 lowing new clause:

22 “(iv) ADJUSTMENT FOR CASE MIX
23 CHANGES.—Insofar as the Secretary determines
24 that the adjustments under paragraph (4)(A)(i) for
25 a previous fiscal year (or estimates that such ad-
26 justments for a future fiscal year) did (or are likely
27 to) result in a change in aggregate payments under
28 this subsection during the fiscal year that are a re-
29 sult of changes in the coding or classification of
30 different units of services that do not reflect real
31 changes in case mix, the Secretary may adjust the
32 standard prospective payment amount (or amounts)
33 under paragraph (3) for subsequent fiscal years so
34 as to eliminate the effect of such coding or classi-
35 fication changes.”.

1 (2) EFFECTIVE DATE.—The amendment made by
2 paragraph (1) applies to episodes concluding on or after
3 October 1, 2001.

4 **SEC. 502. RESTORATION OF FULL HOME HEALTH MAR-**
5 **KET BASKET UPDATE FOR HOME HEALTH**
6 **SERVICES FOR FISCAL YEAR 2001.**

7 (a) IN GENERAL.—Section 1861(v)(1)(L)(x) (42 U.S.C.
8 1395x(v)(1)(L)(x)) is amended—

9 (1) by striking “2001,”; and

10 (2) by adding at the end the following: “With respect
11 to cost reporting periods beginning during fiscal year 2001,
12 the update to any limit under this subparagraph shall be
13 the home health market basket index.”.

14 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR 2001
15 BASED ON ADJUSTED PROSPECTIVE PAYMENT AMOUNTS.—

16 (1) IN GENERAL.—Notwithstanding the amendments
17 made by subsection (a), for purposes of making payments
18 under section 1895(b) of the Social Security Act (42
19 U.S.C. 1395fff(b)) for home health services for fiscal year
20 2001, the Secretary of Health and Human Services shall—

21 (A) with respect to episodes and visits ending on
22 or after October 1, 2000, and before April 1, 2001, use
23 the final standardized and budget neutral prospective
24 payment amounts for 60 day episodes and standardized
25 average per visit amounts for fiscal year 2001 as pub-
26 lished by the Secretary in Federal Register of the July
27 3, 2000 (65 Federal Register 41128–41214); and

28 (B) with respect to episodes and visits ending on
29 or after April 1, 2001, and before October 1, 2001, use
30 such amounts increased by 2.2 percent.

31 (2) NO EFFECT ON OTHER PAYMENTS OR DETERMINA-
32 TIONS.—The Secretary shall not take the provisions of
33 paragraph (1) into account for purposes of payments, de-
34 terminations, or budget neutrality adjustments under sec-
35 tion 1895 of the Social Security Act.

1 **SEC. 503. TEMPORARY TWO-MONTH EXTENSION OF**
2 **PERIODIC INTERIM PAYMENTS.**

3 (a) TEMPORARY EXTENSION.—Notwithstanding subsection
4 (d) of section 4603 of BBA (42 U.S.C. 1395fff note), as
5 amended by section 5101(c)(2) of the Tax and Trade Relief
6 Extension Act of 1998 (contained in division J of Public Law
7 105–277)), the amendments made by subsection (b) of such
8 section 4603 shall not take effect until December 1, 2000, in
9 the case of a home health agency that was receiving periodic
10 interim payments under section 1815(e)(2) as of September 30,
11 2000.

12 (b) PAYMENT RULE.—The amount of such periodic in-
13 terim payment made to a home health agency by reason of sub-
14 section (a) during each of November and December, 2000, shall
15 be equal to the amount of such payment made to the agency
16 in their last full monthly periodic interim payment. Such
17 amount of payment shall be included in the tentative settlement
18 of the last cost report for the home health agency under the
19 payment system in effect prior to the implementation of the
20 prospective payment system under section 1895(b) of the Social
21 Security Act (42 U.S.C. 1395fff(b)).

22 **SEC. 504. USE OF TELEHEALTH IN DELIVERY OF HOME**
23 **HEALTH SERVICES.**

24 Section 1895 (42 U.S.C. 1395fff) is amended by adding
25 at the end the following new subsection:

26 “(e) CONSTRUCTION RELATED TO HOME HEALTH SERV-
27 ICES.—

28 “(1) TELECOMMUNICATIONS.—Nothing in this section
29 shall be construed as preventing a home health agency fur-
30 nishing a home health unit of service for which payment is
31 made under the prospective payment system established by
32 this section for such units of service from furnishing serv-
33 ices via a telecommunication system if such services—

34 “(A) do not substitute for in-person home health
35 services ordered as part of a plan of care certified by
36 a physician pursuant to section 1814(a)(2)(C) or sec-
37 tion 1835(a)(2)(A); and

1 “(B) are not considered a home health visit for
2 purposes of eligibility or payment under this title.

3 “(2) PHYSICIAN CERTIFICATION.—Nothing in this sec-
4 tion shall be construed as waiving the requirement for a
5 physician certification under section 1814(a)(2)(C) or sec-
6 tion 1835(a)(2)(A) of such Act (42 U.S.C. 1395f(a)(2)(C),
7 1395n(a)(2)(A)) for the payment for home health services,
8 whether or not furnished via a telecommunications sys-
9 tem.”.

10 **SEC. 505. STUDY ON COSTS TO HOME HEALTH AGENCIES**
11 **OF PURCHASING NONROUTINE MEDICAL**
12 **SUPPLIES.**

13 (a) STUDY.—The Comptroller General of the United
14 States shall conduct a study on variations in prices paid by
15 home health agencies furnishing home health services under the
16 medicare program under title XVIII of the Social Security Act
17 in purchasing nonroutine medical supplies, including ostomy
18 supplies, and volumes if such supplies used, shall determine the
19 effect (if any) of variations on prices and volumes in the provi-
20 sion of such services.

21 (b) REPORT.—Not later than October 1, 2001, the Comp-
22 troller General shall submit to Congress a report on the study
23 conducted under subsection (a), and shall include in the report
24 recommendations respecting whether payment for nonroutine
25 medical supplies furnished in connection with home health serv-
26 ices should be made separately from the prospective payment
27 system for such services.

28 **SEC. 506. TREATMENT OF BRANCH OFFICES; GAO STUDY**
29 **ON SUPERVISION OF HOME HEALTH CARE**
30 **PROVIDED IN ISOLATED RURAL AREAS.**

31 (a) TREATMENT OF BRANCH OFFICES.—

32 (1) IN GENERAL.—Notwithstanding any other provi-
33 sion of law, in determining for purposes of title XVIII of
34 the Social Security Act whether an office of a home health
35 agency constitutes a branch office or a separate home
36 health agency, neither the time nor distance between a par-
37 ent office of the home health agency and a branch office

1 shall be the sole determinant of a home health agency's
2 branch office status.

3 (2) CONSIDERATION OF FORMS OF TECHNOLOGY IN
4 DEFINITION OF SUPERVISION.—The Secretary of Health
5 and Human Services may include forms of technology in
6 determining what constitutes “supervision” for purposes of
7 determining a home health agency's branch office status
8 under paragraph (1).

9 (b) GAO STUDY.—

10 (1) STUDY.—The Comptroller General of the United
11 States shall conduct a study of the provision of adequate
12 supervision to maintain quality of home health services de-
13 livered under the medicare program under title XVIII of
14 the Social Security Act in isolated rural areas. The study
15 shall evaluate the methods that home health agency
16 branches and subunits use to maintain adequate super-
17 vision in the delivery of services to clients residing in those
18 areas, how these methods of supervision compare to re-
19 quirements that subunits independently meet medicare con-
20 ditions of participation, and the resources utilized by
21 subunits to meet such conditions.

22 (2) REPORT.—Not later than January 1, 2002, the
23 Comptroller General shall submit to Congress a report on
24 the study conducted under paragraph (1). The report shall
25 include recommendations on whether exceptions are needed
26 for subunits and branches of home health agencies under
27 the medicare program to maintain access to the home
28 health benefit or whether alternative policies should be de-
29 veloped to assure adequate supervision and access and rec-
30 ommendations on whether a national standard for super-
31 vision is appropriate.

32 **SEC. 507. CLARIFICATION OF THE HOMEBOUND DEFINI-**
33 **TION UNDER THE MEDICARE HOME HEALTH**
34 **BENEFIT.**

35 (a) CLARIFICATION.—

36 (1) IN GENERAL.—Sections 1814(a) and 1835(a) (42
37 U.S.C. 1395f(a) and 1395n(a)) are each amended—

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1 (A) in the last sentence, by striking “, and that
2 absences of the individual from home are infrequent or
3 of relatively short duration, or are attributable to the
4 need to receive medical treatment”; and

5 (B) by adding at the end the following new sen-
6 tences: “Any absence of an individual from the home
7 attributable to the need to receive health care treat-
8 ment, including regular absences for the purpose of
9 participating in therapeutic, psychosocial, or medical
10 treatment in an adult day-care program that is licensed
11 or certified by a State, or accredited, to furnish adult
12 day-care services in the State shall not disqualify an in-
13 dividual from being considered to be ‘confined to his
14 home’. Any other absence of an individual from the
15 home shall not so disqualify an individual if the ab-
16 sence is of infrequent or of relatively short duration.
17 For purposes of the preceding sentence, any absence
18 for the purpose of attending a religious service shall be
19 deemed to be an absence of infrequent or short dura-
20 tion.”.

21 (2) EFFECTIVE DATE.—The amendments made by
22 paragraph (1) shall apply to items and services provided on
23 or after the date of enactment of this Act.

24 (b) STUDY.—

25 (1) IN GENERAL.—The Comptroller General of the
26 United States shall conduct an evaluation of the effect of
27 the amendment on the cost of and access to home health
28 services under the medicare program under title XVIII of
29 the Social Security Act.

30 (2) REPORT.—Not later than 1 year after the date of
31 the enactment of this Act, the Comptroller General shall
32 submit to Congress a report on the study conducted under
33 paragraph (1).

1 **Subtitle C—Changes in Medicare**
2 **Coverage and Appeals Process**

3 **SEC. 521. REVISIONS TO MEDICARE APPEALS PROCESS.**

4 (a) CONDUCT OF RECONSIDERATIONS OF DETERMINA-
5 TIONS BY INDEPENDENT CONTRACTORS.—Section 1869 (42
6 U.S.C. 1395ff) is amended to read as follows:

7 “DETERMINATIONS; APPEALS

8 “SEC. 1869. (a) INITIAL DETERMINATIONS.—

9 “(1) PROMULGATIONS OF REGULATIONS.—The Sec-
10 retary shall promulgate regulations and make initial deter-
11 minations with respect to benefits under part A or part B
12 in accordance with those regulations for the following:

13 “(A) The initial determination of whether an indi-
14 vidual is entitled to benefits under such parts.

15 “(B) The initial determination of the amount of
16 benefits available to the individual under such parts.

17 “(C) Any other initial determination with respect
18 to a claim for benefits under such parts, including an
19 initial determination by the Secretary that payment
20 may not be made, or may no longer be made, for an
21 item or service under such parts, an initial determina-
22 tion made by a utilization and quality control peer re-
23 view organization under section 1154(a)(2), and an ini-
24 tial determination made by an entity pursuant to a
25 contract (other than a contract under section 1852)
26 with the Secretary to administer provisions of this title
27 or title XI.

28 “(2) DEADLINES FOR MAKING INITIAL DETERMINA-
29 TIONS.—

30 “(A) IN GENERAL.—Subject to subparagraph (B),
31 in promulgating regulations under paragraph (1), ini-
32 tial determinations shall be concluded by not later than
33 the 45-day period beginning on the date the fiscal
34 intermediary or the carrier, as the case may be, re-
35 ceives a claim for benefits from an individual as de-
36 scribed in paragraph (1). Notice of such determination

1 shall be mailed to the individual filing the claim before
2 the conclusion of such 45-day period.

3 “(B) CLEAN CLAIMS.—Subparagraph (A) shall not
4 apply with respect to any claim that is subject to the
5 requirements of section 1816(c)(2) or section
6 1842(c)(2).

7 “(3) REDETERMINATIONS.—

8 “(A) IN GENERAL.—In promulgating regulations
9 under paragraph (1) with respect to initial determina-
10 tions, such regulations shall provide for a fiscal inter-
11 mediary or a carrier to make a redetermination with
12 respect to a claim for benefits that is denied in whole
13 or in part.

14 “(B) LIMITATIONS.—

15 “(i) APPEALS RIGHTS.—No initial determina-
16 tion may be reconsidered or appealed under sub-
17 section (b) unless the fiscal intermediary or carrier
18 has made a redetermination of that initial deter-
19 mination under this paragraph.

20 “(ii) DECISION MAKER.—No redetermination
21 may be made by any individual involved in the ini-
22 tial determination.

23 “(C) DEADLINES.—

24 “(i) FILING FOR REDETERMINATION.—A rede-
25 termination under subparagraph (A) shall be avail-
26 able only if notice is filed with the Secretary to re-
27 quest the redetermination by not later than the end
28 of the 120-day period beginning on the date the in-
29 dividual receives notice of the initial determination
30 under paragraph (2).

31 “(ii) CONCLUDING REDETERMINATIONS.—Redeter-
32 minations shall be concluded by not later than the 30-
33 day period beginning on the date the fiscal inter-
34 mediary or the carrier, as the case may be, receives a
35 request for a redetermination. Notice of such deter-
36 mination shall be mailed to the individual filing the
37 claim before the conclusion of such 30-day period.

1 “(D) CONSTRUCTION.—For purposes of the suc-
2 ceeding provisions of this section a redetermination
3 under this paragraph shall be considered to be part of
4 the initial determination.

5 “(b) APPEAL RIGHTS.—

6 “(1) IN GENERAL.—

7 “(A) RECONSIDERATION OF INITIAL DETERMINA-
8 TION.—Subject to subparagraph (D), any individual
9 dissatisfied with any initial determination under sub-
10 section (a)(1) shall be entitled to reconsideration of the
11 determination, and, subject to subparagraphs (D) and
12 (E), a hearing thereon by the Secretary to the same ex-
13 tent as is provided in section 205(b) and to judicial re-
14 view of the Secretary’s final decision after such hearing
15 as is provided in section 205(g). For purposes of the
16 preceding sentence, any reference to the ‘Commissioner
17 of Social Security’ or the ‘Social Security Administra-
18 tion’ in subsection (g) or (l) of section 205 shall be
19 considered a reference to the ‘Secretary’ or the ‘De-
20 partment of Health and Human Services’, respectively.

21 “(B) REPRESENTATION BY PROVIDER OR SUP-
22 PLIER.—

23 “(i) IN GENERAL.—Sections 206(a), 1102,
24 and 1871 shall not be construed as authorizing the
25 Secretary to prohibit an individual from being rep-
26 resented under this section by a person that fur-
27 nishes or supplies the individual, directly or indi-
28 rectly, with services or items, solely on the basis
29 that the person furnishes or supplies the individual
30 with such a service or item.

31 “(ii) MANDATORY WAIVER OF RIGHT TO PAY-
32 MENT FROM BENEFICIARY.—Any person that fur-
33 nishes services or items to an individual may not
34 represent an individual under this section with re-
35 spect to the issue described in section 1879(a)(2)
36 unless the person has waived any rights for pay-

1 ment from the beneficiary with respect to the serv-
2 ices or items involved in the appeal.

3 “(iii) PROHIBITION ON PAYMENT FOR REP-
4 RESENTATION.—If a person furnishes services or
5 items to an individual and represents the individual
6 under this section, the person may not impose any
7 financial liability on such individual in connection
8 with such representation.

9 “(iv) REQUIREMENTS FOR REPRESENTATIVES
10 OF A BENEFICIARY.—The provisions of section
11 205(j) and section 206 (other than subsection
12 (a)(4) of such section) regarding representation of
13 claimants shall apply to representation of an indi-
14 vidual with respect to appeals under this section in
15 the same manner as they apply to representation of
16 an individual under those sections.

17 “(C) SUCCESSION OF RIGHTS IN CASES OF AS-
18 SIGNMENT.—The right of an individual to an appeal
19 under this section with respect to an item or service
20 may be assigned to the provider of services or supplier
21 of the item or service upon the written consent of such
22 individual using a standard form established by the
23 Secretary for such an assignment.

24 “(D) TIME LIMITS FOR FILING APPEALS.—

25 “(i) RECONSIDERATIONS.—Reconsideration
26 under subparagraph (A) shall be available only if
27 the individual described in subparagraph (A) files
28 notice with the Secretary to request reconsideration
29 by not later than the end of the 180-day period be-
30 ginning on the date the individual receives notice of
31 the redetermination under subsection (a)(3), or
32 within such additional time as the Secretary may
33 allow.

34 “(ii) HEARINGS CONDUCTED BY THE SEC-
35 RETARY.—The Secretary shall establish in regula-
36 tions time limits for the filing of a request for a

1 hearing by the Secretary in accordance with provi-
2 sions in sections 205 and 206.

3 “(E) AMOUNTS IN CONTROVERSY.—

4 “(i) IN GENERAL.—A hearing (by the Sec-
5 retary) shall not be available to an individual under
6 this section if the amount in controversy is less
7 than \$100, and judicial review shall not be avail-
8 able to the individual if the amount in controversy
9 is less than \$1,000.

10 “(ii) AGGREGATION OF CLAIMS.—In deter-
11 mining the amount in controversy, the Secretary,
12 under regulations, shall allow two or more appeals
13 to be aggregated if the appeals involve—

14 “(I) the delivery of similar or related serv-
15 ices to the same individual by one or more pro-
16 viders of services or suppliers, or

17 “(II) common issues of law and fact aris-
18 ing from services furnished to two or more in-
19 dividuals by one or more providers of services
20 or suppliers.

21 “(F) EXPEDITED PROCEEDINGS.—

22 “(i) EXPEDITED DETERMINATION.—In the
23 case of an individual who has received notice by a
24 provider of services that the provider of services
25 plans—

26 “(I) to terminate services provided to an
27 individual and a physician certifies that failure
28 to continue the provision of such services is
29 likely to place the individual’s health at signifi-
30 cant risk, or

31 “(II) to discharge the individual from the
32 provider of services,

33 the individual may request, in writing or orally, an
34 expedited determination or an expedited reconsider-
35 ation of an initial determination made under sub-
36 section (a)(1), as the case may be, and the Sec-

1 retary shall provide such expedited determination
2 or expedited reconsideration.

3 “(ii) EXPEDITED HEARING.—In a hearing by
4 the Secretary under this section, in which the mov-
5 ing party alleges that no material issues of fact are
6 in dispute, the Secretary shall make an expedited
7 determination as to whether any such facts are in
8 dispute and, if not, shall render a decision expedi-
9 tiously.

10 “(G) REOPENING AND REVISION OF DETERMINA-
11 TIONS.—The Secretary may reopen or revise any initial
12 determination or reconsidered determination described
13 in this subsection under guidelines established by the
14 Secretary in regulations.

15 “(c) CONDUCT OF RECONSIDERATIONS BY INDEPENDENT
16 CONTRACTORS.—

17 “(1) IN GENERAL.—The Secretary shall enter into
18 contracts with qualified independent contractors to conduct
19 reconsiderations of initial determinations made under sub-
20 paragraphs (B) and (C) of subsection (a)(1). Contracts
21 shall be for an initial term of three years and shall be re-
22 newable on a triennial basis thereafter.

23 “(2) QUALIFIED INDEPENDENT CONTRACTOR.—For
24 purposes of this subsection, the term ‘qualified independent
25 contractor’ means an entity or organization that is inde-
26 pendent of any organization under contract with the Sec-
27 retary that makes initial determinations under subsection
28 (a)(1), and that meets the requirements established by the
29 Secretary consistent with paragraph (3).

30 “(3) REQUIREMENTS.—Any qualified independent con-
31 tractor entering into a contract with the Secretary under
32 this subsection shall meet the all of the following require-
33 ments:

34 “(A) IN GENERAL.—The qualified independent
35 contractor shall perform such duties and functions and
36 assume such responsibilities as may be required by the
37 Secretary to carry out the provisions of this subsection,

1 and shall have sufficient training and expertise in med-
2 ical science and legal matters to make reconsiderations
3 under this subsection.

4 “(B) RECONSIDERATIONS.—

5 “(i) IN GENERAL.—The qualified independent
6 contractor shall review initial determinations. In
7 the case an initial determination made with respect
8 to whether an item or service is reasonable and
9 necessary for the diagnosis or treatment of illness
10 or injury (under section 1862(a)(1)(A)), such re-
11 view shall include consideration of the facts and
12 circumstances of the initial determination by a
13 panel of physicians or other appropriate health care
14 professionals and any decisions with respect to the
15 reconsideration shall be based on applicable infor-
16 mation, including clinical experience and medical,
17 technical, and scientific evidence.

18 “(ii) EFFECT OF NATIONAL AND LOCAL COV-
19 ERAGE DETERMINATIONS.—

20 “(I) NATIONAL COVERAGE DETERMINA-
21 TIONS.—If the Secretary has made a national
22 coverage determination pursuant to the re-
23 quirements established under the third sentence
24 of section 1862(a), such determination shall be
25 binding on the qualified independent contractor
26 in making a decision with respect to a reconsid-
27 eration under this section.

28 “(II) LOCAL COVERAGE DETERMINA-
29 TIONS.—If the Secretary has made a local cov-
30 erage determination, such determination shall
31 not be binding on the qualified independent
32 contractor in making a decision with respect to
33 a reconsideration under this section. Notwith-
34 standing the previous sentence, the qualified
35 independent contractor shall consider the local
36 coverage determination in making such deci-
37 sion.

1 “(III) ABSENCE OF NATIONAL OR LOCAL
2 COVERAGE DETERMINATION.—In the absence
3 of such a national coverage determination or
4 local coverage determination, the qualified inde-
5 pendent contractor shall make a decision with
6 respect to the reconsideration based on applica-
7 ble information, including clinical experience
8 and medical, technical, and scientific evidence.

9 “(C) DEADLINES FOR DECISIONS.—

10 “(i) RECONSIDERATIONS.—Except as provided
11 in clauses (iii) and (iv), the qualified independent
12 contractor shall conduct and conclude a reconsider-
13 ation under subparagraph (B), and mail the notice
14 of the decision with respect to the reconsideration
15 by not later than the end of the 30-day period be-
16 ginning on the date a request for reconsideration
17 has been timely filed.

18 “(ii) CONSEQUENCES OF FAILURE TO MEET
19 DEADLINE.—In the case of a failure by the quali-
20 fied independent contractor to mail the notice of
21 the decision by the end of the period described in
22 clause (i) or to provide notice by the end of the pe-
23 riod described in clause (iii), as the case may be,
24 the party requesting the reconsideration or appeal
25 may request a hearing before the Secretary, not-
26 withstanding any requirements for a reconsidered
27 determination for purposes of the party’s right to
28 such hearing.

29 “(iii) EXPEDITED RECONSIDERATIONS.—The
30 qualified independent contractor shall perform an
31 expedited reconsideration under subsection
32 (b)(1)(F) as follows:

33 “(I) DEADLINE FOR DECISION.—Notwith-
34 standing section 216(j) and subject to clause
35 (iv), not later than the end of the 72-hour pe-
36 riod beginning on the date the qualified inde-
37 pendent contractor has received a request for

1 such reconsideration and has received such
2 medical or other records needed for such recon-
3 sideration, the qualified independent contractor
4 shall provide notice (by telephone and in writ-
5 ing) to the individual and the provider of serv-
6 ices and attending physician of the individual
7 of the results of the reconsideration. Such re-
8 consideration shall be conducted regardless of
9 whether the provider of services or supplier will
10 charge the individual for continued services or
11 whether the individual will be liable for pay-
12 ment for such continued services.

13 “(II) CONSULTATION WITH BENE-
14 FICIARY.—In such reconsideration, the quali-
15 fied independent contractor shall solicit the
16 views of the individual involved.

17 “(III) SPECIAL RULE FOR HOSPITAL DIS-
18 CHARGES.—A reconsideration of a discharge
19 from a hospital shall be conducted under this
20 clause in accordance with the provisions of
21 paragraphs (2), (3), and (4) of section 1154(e)
22 as in effect on the date that precedes the date
23 of the enactment of this subparagraph.

24 “(iv) EXTENSION.—An individual requesting a
25 reconsideration under this subparagraph may be
26 granted such additional time as the individual
27 specifies (not to exceed 14 days) for the qualified
28 independent contractor to conclude the reconsider-
29 ation. The individual may request such additional
30 time in orally or in writing.

31 “(D) LIMITATION ON INDIVIDUAL REVIEWING DE-
32 TERMINATIONS.—

33 “(i) PHYSICIANS AND HEALTH CARE PROFES-
34 SIONAL.—No physician or health care professional
35 under the employ of a qualified independent con-
36 tractor may review—

1 “(I) determinations regarding health care
2 services furnished to a patient if the physician
3 or health care professional was directly respon-
4 sible for furnishing such services; or

5 “(II) determinations regarding health care
6 services provided in or by an institution, orga-
7 nization, or agency, if the physician or any
8 member of the family of the physician or health
9 care professional has, directly or indirectly, a
10 significant financial interest in such institution,
11 organization, or agency.

12 “(ii) FAMILY DESCRIBED.—For purposes of
13 this paragraph, the family of a physician or health
14 care professional includes the spouse (other than a
15 spouse who is legally separated from the physician
16 or health care professional under a decree of di-
17 vorce or separate maintenance), children (including
18 stepchildren and legally adopted children), grand-
19 children, parents, and grandparents of the physi-
20 cian or health care professional.

21 “(E) EXPLANATION OF DECISION.—Any decision
22 with respect to a reconsideration of a qualified inde-
23 pendent contractor shall be in writing, and shall include
24 a detailed explanation of the decision as well as a dis-
25 cussion of the pertinent facts and applicable regulations
26 applied in making such decision, and in the case of a
27 determination of whether an item or service is reason-
28 able and necessary for the diagnosis or treatment of ill-
29 ness or injury (under section 1862(a)(1)(A)) an expla-
30 nation of the medical and scientific rational for the de-
31 cision.

32 “(F) NOTICE REQUIREMENTS.—Whenever a quali-
33 fied independent contractor makes a decision with re-
34 spect to a reconsideration under this subsection, the
35 qualified independent contractor shall promptly notify
36 the entity responsible for the payment of claims under
37 part A or part B of such decision.

1 “(G) DISSEMINATION OF DECISIONS ON RECON-
2 SIDERATIONS.—Each qualified independent contractor
3 shall make available all decisions with respect to recon-
4 siderations of such qualified independent contractors to
5 fiscal intermediaries (under section 1816), carriers
6 (under section 1842), peer review organizations (under
7 part B of title XI), Medicare+ Choice organizations of-
8 fering Medicare+ Choice plans under part C, other enti-
9 ties under contract with the Secretary to make initial
10 determinations under part A or part B or title XI, and
11 to the public. The Secretary shall establish a method-
12 ology under which qualified independent contractors
13 shall carry out this subparagraph.

14 “(H) ENSURING CONSISTENCY IN DECISIONS.—
15 Each qualified independent contractor shall monitor its
16 decisions with respect to reconsiderations to ensure the
17 consistency of such decisions with respect to requests
18 for reconsideration of similar or related matters.

19 “(I) DATA COLLECTION.—

20 “(i) IN GENERAL.—Consistent with the re-
21 quirements of clause (ii), a qualified independent
22 contractor shall collect such information relevant to
23 its functions, and keep and maintain such records
24 in such form and manner as the Secretary may re-
25 quire to carry out the purposes of this section and
26 shall permit access to and use of any such informa-
27 tion and records as the Secretary may require for
28 such purposes.

29 “(ii) TYPE OF DATA COLLECTED.—Each quali-
30 fied independent contractor shall keep accurate
31 records of each decision made, consistent with
32 standards established by the Secretary for such
33 purpose. Such records shall be maintained in an
34 electronic database in a manner that provides for
35 identification of the following:

36 “(I) Specific claims that give rise to ap-
37 peals.

1 “(II) Situations suggesting the need for
2 increased education for providers of services,
3 physicians, or suppliers.

4 “(III) Situations suggesting the need for
5 changes in national or local coverage policy.

6 “(IV) Situations suggesting the need for
7 changes in local medical review policies.

8 “(iii) ANNUAL REPORTING.—Each qualified
9 independent contractor shall submit annually to the
10 Secretary (or otherwise as the Secretary may re-
11 quest) records maintained under this paragraph for
12 the previous year.

13 “(J) HEARINGS BY THE SECRETARY.—The quali-
14 fied independent contractor shall (i) prepare such infor-
15 mation as is required for an appeal of a decision of the
16 contractor with respect to a reconsideration to the Sec-
17 retary for a hearing, including as necessary, expla-
18 nations of issues involved in the decision and relevant
19 policies, and (ii) participate in such hearings as re-
20 quired by the Secretary.

21 “(4) NUMBER OF QUALIFIED INDEPENDENT CONTRAC-
22 TORS.—The Secretary shall enter into contracts with not
23 fewer than 12 qualified independent contractors under this
24 subsection.

25 “(5) LIMITATION ON QUALIFIED INDEPENDENT CON-
26 TRACTOR LIABILITY.—No qualified independent contractor
27 having a contract with the Secretary under this subsection
28 and no person who is employed by, or who has a fiduciary
29 relationship with, any such qualified independent contractor
30 or who furnishes professional services to such qualified
31 independent contractor, shall be held by reason of the per-
32 formance of any duty, function, or activity required or au-
33 thorized pursuant to this subsection or to a valid contract
34 entered into under this subsection, to have violated any
35 criminal law, or to be civilly liable under any law of the
36 United States or of any State (or political subdivision

1 thereof) provided due care was exercised in the perform-
2 ance of such duty, function, or activity.

3 “(d) DEADLINES FOR HEARINGS BY THE SECRETARY.—

4 “(1) HEARING BY ADMINISTRATIVE LAW JUDGE.—

5 “(A) IN GENERAL.—Except as provided in sub-
6 paragraph (B), an administrative law judge shall con-
7 duct and conclude a hearing on a decision of a qualified
8 independent contractor under subsection (c) and render
9 a decision on such hearing by not later than the end
10 of the 90-day period beginning on the date a request
11 for hearing has been timely filed.

12 “(B) WAIVER OF DEADLINE BY PARTY SEEKING
13 HEARING.—The 90-day period under subparagraph (A)
14 shall not apply in the case of a motion or stipulation
15 by the party requesting the hearing to waive such pe-
16 riod.

17 “(2) DEPARTMENTAL APPEALS BOARD REVIEW.—

18 “(A) IN GENERAL.—The Departmental Appeals
19 Board of the Department of Health and Human Serv-
20 ices shall conduct and conclude a review of the decision
21 on a hearing described in paragraph (1) and make a
22 decision or remand the case to the administrative law
23 judge for reconsideration by not later than the end of
24 the 90-day period beginning on the date a request for
25 review has been timely filed.

26 “(B) DAB HEARING PROCEDURE.—In reviewing a
27 decision on a hearing under this paragraph, the De-
28 partmental Appeals Board shall review the case de
29 novo.

30 “(3) CONSEQUENCES OF FAILURE TO MEET DEAD-
31 LINES.—

32 “(A) HEARING BY ADMINISTRATIVE LAW
33 JUDGE.—In the case of a failure by an administrative
34 law judge to render a decision by the end of the period
35 described in paragraph (1), the party requesting the
36 hearing may request a review by the Departmental Ap-
37 peals Board of the Department of Health and Human

1 Services, notwithstanding any requirements for a hear-
2 ing for purposes of the party's right to such a review.

3 “(B) DEPARTMENTAL APPEALS BOARD REVIEW.—
4 In the case of a failure by the Departmental Appeals
5 Board to render a decision by the end of the period de-
6 scribed in paragraph (2), the party requesting the hear-
7 ing may seek judicial review, notwithstanding any re-
8 quirements for a hearing for purposes of the party's
9 right to such judicial review.

10 “(e) ADMINISTRATIVE PROVISIONS.—

11 “(1) LIMITATION ON REVIEW OF CERTAIN REGULA-
12 TIONS.—A regulation or instruction that relates to a meth-
13 od for determining the amount of payment under part B
14 and that was initially issued before January 1, 1981, shall
15 not be subject to judicial review.

16 “(2) OUTREACH.—The Secretary shall perform such
17 outreach activities as are necessary to inform individuals
18 entitled to benefits under this title and providers of services
19 and suppliers with respect to their rights of, and the proc-
20 ess for, appeals made under this section. The Secretary
21 shall use the toll-free telephone number maintained by the
22 Secretary under section 1804(b) to provide information re-
23 garding appeal rights and respond to inquiries regarding
24 the status of appeals.

25 “(3) CONTINUING EDUCATION REQUIREMENT FOR
26 QUALIFIED INDEPENDENT CONTRACTORS AND ADMINIS-
27 TRATIVE LAW JUDGES.—The Secretary shall provide to
28 each qualified independent contractor, and, in consultation
29 with the Commissioner of Social Security, to administrative
30 law judges that decide appeals of reconsiderations of initial
31 determinations or other decisions or determinations under
32 this section, such continuing education with respect to cov-
33 erage of items and services under this title or policies of
34 the Secretary with respect to part B of title XI as is nec-
35 essary for such qualified independent contractors and ad-
36 ministrative law judges to make informed decisions with re-
37 spect to appeals.

1 “(4) REPORTS.—

2 “(A) ANNUAL REPORT TO CONGRESS.—The Sec-
3 retary shall submit to Congress an annual report de-
4 scribing the number of appeals for the previous year,
5 identifying issues that require administrative or legisla-
6 tive actions, and including any recommendations of the
7 Secretary with respect to such actions. The Secretary
8 shall include in such report an analysis of determina-
9 tions by qualified independent contractors with respect
10 to inconsistent decisions and an analysis of the causes
11 of any such inconsistencies.

12 “(B) SURVEY.—Not less frequently than every 5
13 years, the Secretary shall conduct a survey of a valid
14 sample of individuals entitled to benefits under this
15 title who have filed appeals of determinations under
16 this section, providers of services, and suppliers to de-
17 termine the satisfaction of such individuals or entities
18 with the process for appeals of determinations provided
19 for under this section and education and training pro-
20 vided by the Secretary with respect to that process.
21 The Secretary shall submit to Congress a report de-
22 scribing the results of the survey, and shall include any
23 recommendations for administrative or legislative ac-
24 tions that the Secretary determines appropriate.”.

25 (b) APPLICABILITY OF REQUIREMENTS AND LIMITATIONS
26 ON LIABILITY OF QUALIFIED INDEPENDENT CONTRACTORS TO
27 MEDICARE+ CHOICE INDEPENDENT APPEALS CONTRAC-
28 TORS.—Section 1852(g)(4) (42 U.S.C. 1395w-22(g)(4)) is
29 amended by adding at the end the following: “The provisions
30 of section 1869(c)(5) shall apply to independent outside entities
31 under contract with the Secretary under this paragraph.”.

32 (c) CONFORMING AMENDMENT.—Section 1154(e) (42
33 U.S.C. 1320c-3(e)) is amended by striking paragraphs (2), (3),
34 and (4).

35 (d) EFFECTIVE DATE.—The amendments made by this
36 section apply with respect to initial determinations made on or
37 after October 1, 2002.

1 **SEC. 522. REVISIONS TO MEDICARE COVERAGE PROC-**
2 **ESS.**

3 (a) REVIEW OF DETERMINATIONS.—Section 1869 (42
4 U.S.C. 1395ff), as amended by section 521, is further amended
5 by adding at the end the following new subsection:

6 “(f) REVIEW OF COVERAGE DETERMINATIONS.—

7 “(1) NATIONAL COVERAGE DETERMINATIONS.—

8 “(A) IN GENERAL.—Review of any national cov-
9 erage determination shall be subject to the following
10 limitations:

11 “(i) Such a determination shall not be re-
12 viewed by any administrative law judge.

13 “(ii) Such a determination shall not be held
14 unlawful or set aside on the ground that a require-
15 ment of section 553 of title 5, United States Code,
16 or section 1871(b) of this title, relating to publica-
17 tion in the Federal Register or opportunity for pub-
18 lic comment, was not satisfied.

19 “(iii) Upon the filing of a complaint by an ag-
20 grieved party, such a determination shall be re-
21 viewed by the Departmental Appeals Board of the
22 Department of Health and Human Services. In
23 conducting such a review, the Departmental Ap-
24 peals Board shall review the record and shall per-
25 mit discovery and the taking of evidence to evaluate
26 the reasonableness of the determination, if the
27 Board determines that the record is incomplete or
28 lacks adequate information to support the validity
29 of the determination. In reviewing such a deter-
30 mination, the Departmental Appeals Board shall
31 defer only to the reasonable findings of fact, rea-
32 sonable interpretations of law, and reasonable ap-
33 plications of fact to law by the Secretary.

34 “(iv) A decision of the Departmental Appeals
35 Board constitutes a final agency action and is sub-
36 ject to judicial review.

1 “(B) DEFINITION OF NATIONAL COVERAGE DE-
2 TERMINATION.—For purposes of this section, the term
3 ‘national coverage determination’ means a determina-
4 tion by the Secretary with respect to whether or not a
5 particular item or service is covered nationally under
6 this title, but does not include a determination of what
7 code, if any, is assigned to a particular item or service
8 covered under this title or a determination with respect
9 to the amount of payment made for a particular item
10 or service so covered.

11 “(2) LOCAL COVERAGE DETERMINATION.—

12 “(A) IN GENERAL.—Review of any local coverage
13 determination shall be subject to the following limita-
14 tions:

15 “(i) Upon the filing of a complaint by an ag-
16 grievied party, such a determination shall be re-
17 viewed by an administrative law judge of the Social
18 Security Administration. The administrative law
19 judge shall review the record and shall permit dis-
20 covery and the taking of evidence to evaluate the
21 reasonableness of the determination, if the adminis-
22 trative law judge determines that the record is in-
23 complete or lacks adequate information to support
24 the validity of the determination. In reviewing such
25 a determination, the administrative law judge shall
26 defer only to the reasonable findings of fact, rea-
27 sonable interpretations of law, and reasonable ap-
28 plications of fact to law by the Secretary.

29 “(ii) Upon the filing of a complaint by an ag-
30 grievied party, a decision of an administrative law
31 judge under clause (i) shall be reviewed by the De-
32 partmental Appeals Board of the Department of
33 Health and Human Services.

34 “(iii) A decision of the Departmental Appeals
35 Board constitutes a final agency action and is sub-
36 ject to judicial review.

1 “(B) DEFINITION OF LOCAL COVERAGE DETER-
2 MINATION.—For purposes of this section, the term
3 ‘local coverage determination’ means a determination
4 by a fiscal intermediary or a carrier under part A or
5 part B, as applicable, respecting whether or not a par-
6 ticular item or service is covered on an intermediary-
7 or carrier-wide basis under such parts, in accordance
8 with section 1862(a)(1)(A).

9 “(3) NO MATERIAL ISSUES OF FACT IN DISPUTE.—In
10 the case of a determination that may otherwise be subject
11 to review under paragraph (1)(A)(iii) or paragraph
12 (2)(A)(i), where the moving party alleges that—

13 “(A) there are no material issues of fact in dis-
14 pute, and

15 “(B) the only issue of law is the constitutionality
16 of a provision of this title, or that a regulation, deter-
17 mination, or ruling by the Secretary is invalid,
18 the moving party may seek review by a court of competent
19 jurisdiction without filing a complaint under such para-
20 graph and without otherwise exhausting other administra-
21 tive remedies.

22 “(4) PENDING NATIONAL COVERAGE DETERMINA-
23 TIONS.—

24 “(A) IN GENERAL.—In the event the Secretary
25 has not issued a national coverage or noncoverage de-
26 termination with respect to a particular type or class
27 of items or services, an aggrieved person (as described
28 in paragraph (5)) may submit to the Secretary a re-
29 quest to make such a determination with respect to
30 such items or services. By not later than the end of the
31 90-day period beginning on the date the Secretary re-
32 ceives such a request (notwithstanding the receipt by
33 the Secretary of new evidence (if any) during such 90-
34 day period), the Secretary shall take one of the fol-
35 lowing actions:

36 “(i) Issue a national coverage determination,
37 with or without limitations.

1 “(ii) Issue a national noncoverage determina-
2 tion.

3 “(iii) Issue a determination that no national
4 coverage or noncoverage determination is appro-
5 priate as of the end of such 90-day period with re-
6 spect to national coverage of such items or services.

7 “(iv) Issue a notice that states that the Sec-
8 retary has not completed a review of the request
9 for a national coverage determination and that in-
10 cludes an identification of the remaining steps in
11 the Secretary’s review process and a deadline by
12 which the Secretary will complete the review and
13 take an action described in subclause (I), (II), or
14 (III).

15 “(B) In the case of an action described in clause
16 (i)(IV), if the Secretary fails to take an action referred
17 to in such clause by the deadline specified by the Sec-
18 retary under such clause, then the Secretary is deemed
19 to have taken an action described in clause (i)(III) as
20 of the deadline.

21 “(C) When issuing a determination under clause
22 (i), the Secretary shall include an explanation of the
23 basis for the determination. An action taken under
24 clause (i) (other than subclause (IV)) is deemed to be
25 a national coverage determination for purposes of re-
26 view under subparagraph (A).

27 “(5) STANDING.—An action under this subsection
28 seeking review of a national coverage determination or local
29 coverage determination may be initiated only by individuals
30 entitled to benefits under part A, or enrolled under part B,
31 or both, who are in need of the items or services that are
32 the subject of the coverage determination.

33 “(6) PUBLICATION ON THE INTERNET OF DECISIONS
34 OF HEARINGS OF THE SECRETARY.—Each decision of a
35 hearing by the Secretary with respect to a national cov-
36 erage determination shall be made public, and the Sec-
37 retary shall publish each decision on the Medicare Internet

1 site of the Department of Health and Human Services. The
2 Secretary shall remove from such decision any information
3 that would identify any individual, provider of services, or
4 supplier.

5 “(7) ANNUAL REPORT ON NATIONAL COVERAGE DE-
6 TERMINATIONS.—

7 “(A) IN GENERAL.—Not later than December 1 of
8 each year, beginning in 2001, the Secretary shall sub-
9 mit to Congress a report that sets forth a detailed com-
10 pilation of the actual time periods that were necessary
11 to complete and fully implement national coverage de-
12 terminations that were made in the previous fiscal year
13 for items, services, or medical devices not previously
14 covered as a benefit under this title, including, with re-
15 spect to each new item, service, or medical device, a
16 statement of the time taken by the Secretary to make
17 and implement the necessary coverage, coding, and
18 payment determinations, including the time taken to
19 complete each significant step in the process of making
20 and implementing such determinations.

21 “(B) PUBLICATION OF REPORTS ON THE INTER-
22 NET.—The Secretary shall publish each report sub-
23 mitted under clause (i) on the medicare Internet site of
24 the Department of Health and Human Services.

25 “(8) CONSTRUCTION.—Nothing in this subsection
26 shall be construed as permitting administrative or judicial
27 review pursuant to this section insofar as such review is ex-
28 plicitly prohibited or restricted under another provision of
29 law.”.

30 (b) ESTABLISHMENT OF A PROCESS FOR COVERAGE DE-
31 TERMINATIONS.—Section 1862(a) (42 U.S.C. 1395y(a)) is
32 amended by adding at the end the following new sentence: “In
33 making a national coverage determination (as defined in para-
34 graph (1)(B) of section 1869(f)) the Secretary shall ensure
35 that the public is afforded notice and opportunity to comment
36 prior to implementation by the Secretary of the determination;
37 meetings of advisory committees established under section

1 1114(f) with respect to the determination are made on the
2 record; in making the determination, the Secretary has consid-
3 ered applicable information (including clinical experience and
4 medical, technical, and scientific evidence) with respect to the
5 subject matter of the determination; and in the determination,
6 provide a clear statement of the basis for the determination (in-
7 cluding responses to comments received from the public), the
8 assumptions underlying that basis, and make available to the
9 public the data (other than proprietary data) considered in
10 making the determination.”.

11 (c) IMPROVEMENTS TO THE MEDICARE ADVISORY COM-
12 MITTEE PROCESS.—Section 1114 (42 U.S.C. 1314) is amended
13 by adding at the end the following new subsection:

14 “(i)(1) Any advisory committee appointed under sub-
15 section (f) to advise the Secretary on matters relating to the
16 interpretation, application, or implementation of section
17 1862(a)(1) shall assure the full participation of a nonvoting
18 member in the deliberations of the advisory committee, and
19 shall provide such nonvoting member access to all information
20 and data made available to voting members of the advisory
21 committee, other than information that—

22 “(A) is exempt from disclosure pursuant to subsection
23 (a) of section 552 of title 5, United States Code, by reason
24 of subsection (b)(4) of such section (relating to trade se-
25 crets); or

26 “(B) the Secretary determines would present a conflict
27 of interest relating to such nonvoting member.

28 “(2) If an advisory committee described in paragraph (1)
29 organizes into panels of experts according to types of items or
30 services considered by the advisory committee, any such panel
31 of experts may report any recommendation with respect to such
32 items or services directly to the Secretary without the prior ap-
33 proval of the advisory committee or an executive committee
34 thereof.”.

35 (d) EFFECTIVE DATE.—The amendments made by this
36 section apply with respect to—

1 (1) a review of any national or local coverage deter-
2 mination filed,

3 (2) a request to make such a determination made,

4 (3) a national coverage determination made,

5 on or after October 1, 2001.

6 **Subtitle D—Improving Access to New**
7 **Technologies**

8 **SEC. 531. REIMBURSEMENT IMPROVEMENTS FOR NEW**
9 **CLINICAL LABORATORY TESTS AND DURA-**
10 **BLE MEDICAL EQUIPMENT.**

11 (a) PAYMENT RULE FOR NEW LABORATORY TESTS.—Sec-
12 tion 1833(h)(4)(B)(viii) (42 U.S.C. 1395l(h)(4)(B)(viii)) is
13 amended by inserting before the period at the end the fol-
14 lowing: “(or 100 percent of such median in the case of a clin-
15 ical diagnostic laboratory test performed on or after January
16 1, 2001, that the Secretary determines is a new test for which
17 no limitation amount has previously been established under this
18 subparagraph)”.

19 (b) ESTABLISHMENT OF CODING AND PAYMENT PROCE-
20 DURES FOR NEW CLINICAL DIAGNOSTIC LABORATORY TESTS
21 AND OTHER ITEMS ON A FEE SCHEDULE.—Not later than 1
22 year after the date of the enactment of this Act, the Secretary
23 of Health and Human Services shall establish procedures for
24 coding and payment determinations for the categories of new
25 clinical diagnostic laboratory tests and new durable medical
26 equipment under part B of the title XVIII of the Social Secu-
27 rity Act that permit public consultation in a manner consistent
28 with the procedures established for implementing coding modi-
29 fications for ICD-9-CM.

30 (c) REPORT ON PROCEDURES USED FOR ADVANCED, IM-
31 PROVED TECHNOLOGIES.—Not later than 1 year after the date
32 of the enactment of this Act, the Secretary of Health and
33 Human Services shall submit to Congress a report that identi-
34 fies the specific procedures used by the Secretary under part
35 B of title XVIII of the Social Security Act to adjust payments
36 for clinical diagnostic laboratory tests and durable medical
37 equipment which are classified to existing codes where, because

1 of an advance in technology with respect to the test or equip-
2 ment, there has been a significant increase or decrease in the
3 resources used in the test or in the manufacture of the equip-
4 ment, and there has been a significant improvement in the per-
5 formance of the test or equipment. The report shall include
6 such recommendations for changes in law as may be necessary
7 to assure fair and appropriate payment levels under such part
8 for such improved tests and equipment as reflects increased
9 costs necessary to produce improved results.

10 **SEC. 532. RETENTION OF HCPCS LEVEL III CODES.**

11 (a) IN GENERAL.—The Secretary of Health and Human
12 Services shall maintain and continue the use of level III codes
13 of the HCPCS coding system (as such system was in effect on
14 August 16, 2000) through December 31, 2003, and shall make
15 such codes available to the public.

16 (b) DEFINITION.—For purposes of this section, the term
17 “HCPCS Level III codes” means the alphanumeric codes for
18 local use under the Health Care Financing Administration
19 Common Procedure Coding System (HCPCS).

20 **SEC. 533. RECOGNITION OF NEW MEDICAL TECH-**
21 **NOLOGIES UNDER INPATIENT HOSPITAL**
22 **PPS.**

23 (a) EXPEDITING RECOGNITION OF NEW TECHNOLOGIES
24 INTO INPATIENT PPS CODING SYSTEM.—

25 (1) REPORT.—Not later than April 1, 2001, the Sec-
26 retary of Health and Human Services shall submit to Con-
27 gress a report on methods of expeditiously incorporating
28 new medical services and technologies into the clinical cod-
29 ing system used with respect to payment for inpatient hos-
30 pital services furnished under the medicare program under
31 title XVIII of the Social Security Act, together with a de-
32 tailed description of the Secretary’s preferred methods to
33 achieve this purpose.

34 (2) IMPLEMENTATION.—Not later than October 1,
35 2001, the Secretary shall implement the preferred methods
36 described in the report transmitted pursuant to paragraph
37 (1).

133

1 (b) ENSURING APPROPRIATE PAYMENTS FOR HOSPITALS
2 INCORPORATING NEW MEDICAL SERVICES AND TECH-
3 NOLOGIES.—

4 (1) ESTABLISHMENT OF MECHANISM.—Section
5 1886(d)(5) (42 U.S.C. 1395ww(d)(5)) is amended by add-
6 ing at the end the following new subparagraphs:

7 “(K)(i) Effective for discharges beginning on or after Oc-
8 tober 1, 2001, the Secretary shall establish a mechanism to
9 recognize the costs of new medical services and technologies
10 under the payment system established under this subsection.
11 Such mechanism shall be established after notice and oppor-
12 tunity for public comment (in the publications required by sub-
13 section (e)(5) for a fiscal year or otherwise).

14 “(ii) The mechanism established pursuant to clause (i)
15 shall—

16 “(I) apply to a new medical service or technology if,
17 based on the estimated costs incurred with respect to dis-
18 charges involving such service or technology, the DRG pro-
19 spective payment rate otherwise applicable to such dis-
20 charges under this subsection is inadequate;

21 “(II) provide for the collection of data with respect to
22 the costs of a new medical service or technology described
23 in subclause (I) for a period of not less than two years and
24 not more than three years beginning on the date on which
25 an inpatient hospital code is issued with respect to the
26 service or technology;

27 “(III) subject to paragraph (4)(C)(iii), provide for ad-
28 ditional payment to be made under this subsection with re-
29 spect to discharges involving a new medical service or tech-
30 nology described in subclause (I) that occur during the pe-
31 riod described in subclause (II) in an amount that ade-
32 quately reflects the estimated average cost of such service
33 or technology; and

34 “(IV) provide that discharges involving such a service
35 or technology that occur after the close of the period de-
36 scribed in subclause (II) will be classified within a new or
37 existing diagnosis-related group with a weighting factor

1 under paragraph (4)(B) that is derived from cost data col-
2 lected with respect to discharges occurring during such pe-
3 riod.

4 “(iii) For purposes of clause (ii)(II), the term ‘inpatient
5 hospital code’ means any code that is used with respect to inpa-
6 tient hospital services for which payment may be made under
7 this subsection and includes an alphanumeric code issued under
8 the International Classification of Diseases, 9th Revision, Clin-
9 ical Modification (‘ICD-9-CM’) and its subsequent revisions.

10 “(iv) For purposes of clause (ii)(III), the term ‘additional
11 payment’ means, with respect to a discharge for a new medical
12 service or technology described in clause (ii)(I), an amount that
13 exceeds the prospective payment rate otherwise applicable
14 under this subsection to discharges involving such service or
15 technology that would be made but for this subparagraph.

16 “(v) The requirement under clause (ii)(III) for an addi-
17 tional payment may be satisfied by means of a new-technology
18 group (described in subparagraph (L)), an add-on payment, a
19 payment adjustment, or any other similar mechanism for in-
20 creasing the amount otherwise payable with respect to a dis-
21 charge under this subsection. The Secretary may not establish
22 a separate fee schedule for such additional payment for such
23 services and technologies, by utilizing a methodology estab-
24 lished under subsection (a) or (h) of section 1834 to determine
25 the amount of such additional payment, or by other similar
26 mechanisms or methodologies.

27 “(vi) For purposes of this subparagraph and subparagraph
28 (L), a medical service or technology will be considered a ‘new
29 medical service or technology’ if the service or technology meets
30 criteria established by the Secretary after notice and an oppor-
31 tunity for public comment.

32 “(L)(i) In establishing the mechanism under subparagraph
33 (K), the Secretary may establish new-technology groups into
34 which a new medical service or technology will be classified if,
35 based on the estimated average costs incurred with respect to
36 discharges involving such service or technology, the DRG pro-

1 spective payment rate otherwise applicable to such discharges
2 under this subsection is inadequate.

3 “(ii) Such groups—

4 “(I) shall not be based on the costs associated with a
5 specific new medical service or technology; but

6 “(II) shall, in combination with the applicable stand-
7 ardized amounts and the weighting factors assigned to such
8 groups under paragraph (4)(B), reflect such cost cohorts as
9 the Secretary determines are appropriate for all new med-
10 ical services and technologies that are likely to be provided
11 as inpatient hospital services in a fiscal year.

12 “(iii) The methodology for classifying specific hospital dis-
13 charges within a diagnosis-related group under paragraph
14 (4)(A) or a new-technology group shall provide that a specific
15 hospital discharge may not be classified within both a diag-
16 nosis-related group and a new-technology group.”.

17 (2) PRIOR CONSULTATION.—The Secretary of Health
18 and Human Services shall consult with groups representing
19 hospitals, physicians, and manufacturers of new medical
20 technologies before publishing the notice of proposed rule-
21 making required by section 1886(d)(5)(K)(i) of the Social
22 Security Act (as added by paragraph (1)).

23 (3) CONFORMING AMENDMENT.—Section
24 1886(d)(4)(C)(i) (42 U.S.C. 1395ww(d)(4)(C)(i)) is
25 amended by striking “technology,” and inserting “tech-
26 nology (including a new medical service or technology under
27 paragraph (5)(K)),”.

28 **Subtitle E—Other Provisions**

29 **SEC. 541. INCREASE IN REIMBURSEMENT FOR BAD** 30 **DEBT.**

31 Section 1861(v)(1)(T) (42 U.S.C. 1395x(v)(1)(T)) is
32 amended—

33 (1) in clause (ii), by striking “and” at the end;

34 (2) in clause (iii)—

35 (A) by striking “during a subsequent fiscal year”
36 and inserting “during fiscal year 2000”; and

- 1 (B) by striking the period at the end and inserting
2 “, and”; and
3 (3) by adding at the end the following new clause:
4 “(iv) for cost reporting periods beginning during a
5 subsequent fiscal year, by 30 percent of such amount other-
6 wise allowable.”.

7 **SEC. 542. TREATMENT OF CERTAIN PHYSICIAN PATHOL-**
8 **OGY SERVICES UNDER MEDICARE.**

9 (a) IN GENERAL.—When an independent laboratory fur-
10 nishes the technical component of a physician pathology service
11 to a fee-for-service medicare beneficiary who is an inpatient or
12 outpatient of a covered hospital, the Secretary of Health and
13 Human Services shall treat such component as a service for
14 which payment shall be made to the laboratory under section
15 1848 of the Social Security Act (42 U.S.C. 1395w-4) and not
16 as an inpatient hospital service for which payment is made to
17 the hospital under section 1886(d) of such Act (42 U.S.C.
18 1395ww(d)) or as an outpatient hospital service for which pay-
19 ment is made to the hospital under section 1833(t) of such Act
20 (42 U.S.C. 1395l(t)).

21 (b) DEFINITIONS.—For purposes of this section:

22 (1) COVERED HOSPITAL.—The term “covered hos-
23 pital” means, with respect to an inpatient or an outpatient,
24 a hospital that had an arrangement with an independent
25 laboratory that was in effect as of July 22, 1999, under
26 which a laboratory furnished the technical component of
27 physician pathology services to fee-for-service medicare
28 beneficiaries who were hospital inpatients or outpatients,
29 respectively, and submitted claims for payment for such
30 component to a medicare carrier (that has a contract with
31 the Secretary under section 1842 of the Social Security
32 Act, 42 U.S.C. 1395u) and not to such hospital.

33 (2) FEE-FOR-SERVICE MEDICARE BENEFICIARY.—The
34 term “fee-for-service medicare beneficiary” means an indi-
35 vidual who—

36 (A) is entitled to benefits under part A, or enrolled
37 under part B, or both, of such title; and

1 (B) is not enrolled in any of the following:

2 (i) A Medicare+ Choice plan under part C of
3 such title.

4 (ii) A plan offered by an eligible organization
5 under section 1876 of such Act (42 U.S.C.
6 1395mm).

7 (iii) A program of all-inclusive care for the el-
8 derly (PACE) under section 1894 of such Act (42
9 U.S.C. 1395eee).

10 (iv) A social health maintenance organization
11 (SHMO) demonstration project established under
12 section 4018(b) of the Omnibus Budget Reconcili-
13 ation Act of 1987 (Public Law 100-203).

14 (c) EFFECTIVE DATE.—This section applies to services
15 furnished during the 2-year period beginning on January 1,
16 2001.

17 (d) GAO REPORT.—

18 (1) STUDY.—The Comptroller General of the United
19 States shall conduct a study of the effects of the previous
20 provisions of this section on hospitals and laboratories and
21 access of fee-for-service medicare beneficiaries to the tech-
22 nical component of physician pathology services.

23 (2) REPORT.—Not later than April 1, 2002, the
24 Comptroller General shall submit to Congress a report on
25 such study. The report shall include recommendations
26 about whether such provisions should be extended after the
27 end of the period specified in subsection (c) for either or
28 both inpatient and outpatient hospital services, and wheth-
29 er the provisions should be extended to other hospitals.

30 **SEC. 543. EXTENSION OF ADVISORY OPINION AUTHOR-**
31 **ITY.**

32 Section 1128D(b)(6) (42 U.S.C. 1320a-7d(b)(6)) is
33 amended by striking “and before the date which is 4 years
34 after such date of enactment”.

35 **SEC. 544. CHANGE IN ANNUAL MEDPAC REPORTING.**

36 (a) REVISION OF DEADLINES FOR SUBMISSION OF RE-
37 PORTS.—

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1 (1) IN GENERAL.—Section 1805(b)(1)(D) (42 U.S.C.
2 1395b–6(b)(1)(D)) is amended by striking “June 1 of each
3 year (beginning with 1998),” and inserting “June 15 of
4 each year,”.

5 (2) EFFECTIVE DATE.—The amendment made by
6 paragraph (1) applies beginning with 2001.

7 (b) REQUIREMENT FOR ON THE RECORD VOTES ON REC-
8 OMMENDATIONS.—Section 1805(b) (42 U.S.C. 1395b–6(b)) is
9 amended by adding at the end the following new paragraph:

10 “(7) VOTING AND REPORTING REQUIREMENTS.—With
11 respect to each recommendation contained in a report sub-
12 mitted under paragraph (1), each member of the Commis-
13 sion shall vote on the recommendation, and the Commission
14 shall include, by member, the results of that vote in the re-
15 port containing the recommendation.”.

16 **SEC. 545. DEVELOPMENT OF PATIENT ASSESSMENT IN-**
17 **STRUMENTS.**

18 (a) DEVELOPMENT.—

19 (1) IN GENERAL.—Not later than January 1, 2005,
20 the Secretary of Health and Human Services shall submit
21 to the Committee on Ways and Means and the Committee
22 on Commerce of the House of Representatives and the
23 Committee on Finance of the Senate a report on the devel-
24 opment of standard instruments for the assessment of the
25 health and functional status of patients, for whom items
26 and services described in subsection (b) are furnished, and
27 include in the report a recommendation on the use of such
28 standard instruments for payment purposes.

29 (2) DESIGN FOR COMPARISON OF COMMON ELE-
30 MENTS.—The Secretary shall design such standard instru-
31 ments in a manner such that—

32 (A) elements that are common to the items and
33 services described in subsection (b) may be readily com-
34 parable and are statistically compatible;

35 (B) only elements necessary to meet program ob-
36 jectives are collected; and

1 (C) the standard instruments supersede any other
2 assessment instrument used before that date.

3 (3) CONSULTATION.—In developing an assessment in-
4 strument under paragraph (1), the Secretary shall consult
5 with the Medicare Payment Advisory Commission, the
6 Agency for Healthcare Research and Quality, and qualified
7 organizations representing providers of services and sup-
8 pliers under title XVIII.

9 (b) DESCRIPTION OF SERVICES.—For purposes of sub-
10 section (a), items and services described in this subsection are
11 those items and services furnished to individuals entitled to
12 benefits under part A, or enrolled under part B, or both of title
13 XVIII of the Social Security Act for which payment is made
14 under such title, and include the following:

- 15 (1) Inpatient and outpatient hospital services.
- 16 (2) Inpatient and outpatient rehabilitation services.
- 17 (3) Covered skilled nursing facility services.
- 18 (4) Home health services.
- 19 (5) Physical or occupational therapy or speech-lan-
20 guage pathology services.
- 21 (6) Items and services furnished to such individuals
22 determined to have end stage renal disease.
- 23 (7) Partial hospitalization services and other mental
24 health services.
- 25 (8) Any other service for which payment is made
26 under such title as the Secretary determines to be appro-
27 priate.

28 **SEC. 546. GAO REPORT ON IMPACT OF THE EMERGENCY**
29 **MEDICAL TREATMENT AND ACTIVE LABOR**
30 **ACT (EMTALA) ON HOSPITAL EMERGENCY**
31 **DEPARTMENTS.**

32 (a) REPORT.—The Comptroller General of the United
33 States shall submit a report to the Committee on Commerce
34 and the Committee on Ways and Means of the House of Rep-
35 resentatives and the Committee on Finance of the Senate by
36 May 1, 2001, on the effect of the Emergency Medical Treat-
37 ment and Active Labor Act on hospitals, emergency physicians,

1 and physicians covering emergency department call throughout
2 the United States.

3 (b) REPORT REQUIREMENTS.—The report should
4 evaluate—

5 (1) the extent to which hospitals, emergency physi-
6 cians, and physicians covering emergency department call
7 provide uncompensated services in relation to the require-
8 ments of EMTALA;

9 (2) the extent to which the regulatory requirements
10 and enforcement of EMTALA have expanded beyond the
11 legislation's original intent;

12 (3) estimates for the total dollar amount of EMTALA-
13 related care uncompensated costs to emergency physicians,
14 physicians covering emergency department call, hospital
15 emergency departments, and other hospital services;

16 (4) the extent to which different portions of the
17 United States may be experiencing different levels of un-
18 compensated EMTALA-related care;

19 (5) the extent to which EMTALA would be classified
20 as an unfunded mandate if it were enacted today;

21 (6) the extent to which States have programs to pro-
22 vide financial support for such uncompensated care;

23 (7) possible sources of funds, including medicare hos-
24 pital bad debt accounts, that are available to hospitals to
25 assist with the cost of such uncompensated care; and

26 (8) the financial strain that illegal immigration popu-
27 lations, the uninsured, and the underinsured place on hos-
28 pital emergency departments, other hospital services, emer-
29 gency physicians, and physicians covering emergency de-
30 partment call.

31 (c) DEFINITION.—In this section, the terms “Emergency
32 Medical Treatment and Active Labor Act” and “EMTALA”
33 mean section 1867 of the Social Security Act (42 U.S.C.
34 1395dd).

1 **TITLE VI—PROVISIONS RELATING**
2 **TO PART C (MEDICARE+CHOICE**
3 **PROGRAM) AND OTHER MEDI-**
4 **CARE MANAGED CARE PROVI-**
5 **SIONS**

6 **Subtitle A—Medicare+Choice**
7 **Payment Reforms**

8 **SEC. 601. INCREASE IN MINIMUM PAYMENT AMOUNT.**

9 Section 1853(c)(1)(B)(ii) (42 U.S.C. 1395w-
10 23(c)(1)(B)(ii)) is amended—

11 (1) by striking “(ii) For a succeeding year” and in-
12 sserting “(ii)(I) Subject to subclauses (II) and (III), for a
13 succeeding year”; and

14 (2) by adding at the end the following new subclauses:

15 “(II) For 2001, for any area in a Metropolitan
16 Statistical Area within any of the 50 States and
17 the District of Columbia with a population of more
18 than 250,000, \$525 (and for any other area within
19 any of the 50 States, \$475).

20 “(III) For 2001, for any area in a Metropoli-
21 tan Statistical Area outside the 50 States and the
22 District of Columbia with a population of more
23 than 250,000, \$525 (and for any other area out-
24 side the 50 States and the District of Columbia,
25 \$475), but not to exceed 120 percent of the
26 amount determined under this subparagraph for
27 such area for 2000.”.

28 **SEC. 602. INCREASE IN MINIMUM PERCENTAGE IN-**
29 **CREASE.**

30 Section 1853(c)(1)(C)(ii) (42 U.S.C. 1395w-
31 23(c)(1)(C)(ii)) is amended by inserting “(or 103 percent in
32 the case of 2001)” after “102 percent”.

33 **SEC. 603. 10-YEAR PHASE-IN OF RISK ADJUSTMENT.**

34 Section 1853(a)(3)(C)(ii) (42 U.S.C. 1395w-
35 23(a)(3)(C)(ii)) is amended—

1 (1) in subclause (I), by striking “and 2001” and in-
2 serting “and each succeeding year through the first year in
3 which risk adjustment is based on data from inpatient hos-
4 pital and ambulatory settings”; and

5 (2) by amending subclause (II) to read as follows:

6 “(II) beginning after such first year, inso-
7 far as such risk adjustment is based on data
8 from inpatient hospital and ambulatory set-
9 tings, the methodology shall be phased in equal
10 increments over a 10-year period that begins
11 with such first year.”.

12 **SEC. 604. TRANSITION TO REVISED MEDICARE+CHOICE**
13 **PAYMENT RATES.**

14 (a) ANNOUNCEMENT OF REVISED MEDICARE+ CHOICE
15 PAYMENT RATES.—Within 2 weeks after the date of the enact-
16 ment of this Act, the Secretary of Health and Human Services
17 shall determine, and shall announce (in a manner intended to
18 provide notice to interested parties) Medicare+ Choice capita-
19 tion rates under section 1853 of the Social Security Act (42
20 U.S.C. 1395w-23) for 2001, revised in accordance with the
21 provisions of this Act.

22 (b) REENTRY INTO PROGRAM PERMITTED FOR
23 MEDICARE+ CHOICE PROGRAMS IN 2000.—A Medicare+ Choice
24 organization that provided notice to the Secretary of Health
25 and Human Services before the date of the enactment of this
26 Act that it was terminating its contract under part C of title
27 XVIII of the Social Security Act or was reducing the service
28 area of a Medicare+ Choice plan offered under such part shall
29 be permitted to continue participation under such part, or to
30 maintain the service area of such plan, for 2001 if it provides
31 the Secretary with the information described in section
32 1854(a)(1) of the Social Security Act (42 U.S.C. 1395w-
33 24(a)(1)) within 2 weeks after the date revised rates are an-
34 nounced by the Secretary under subsection (a).

35 (c) REVISED SUBMISSION OF PROPOSED PREMIUMS AND
36 RELATED INFORMATION.—If—

1 (1) a Medicare+ Choice organization provided notice to
2 the Secretary of Health and Human Services as of July 3,
3 2000, that it was renewing its contract under part C of
4 title XVIII of the Social Security Act for all or part of the
5 service area or areas served under its current contract, and

6 (2) any part of the service area or areas addressed in
7 such notice includes a payment area for which the
8 Medicare+ Choice capitation rate under section 1853(c) of
9 such Act (42 U.S.C. 1395w-23(c)) for 2001, as determined
10 under subsection (a), is higher than the rate previously de-
11 termined for such year,

12 such organization shall revise its submission of the information
13 described in section 1854(a)(1) of the Social Security Act (42
14 U.S.C. 1395w-24(a)(1)), and shall submit such revised infor-
15 mation to the Secretary, within 2 weeks after the date revised
16 rates are announced by the Secretary under subsection (a). In
17 making such submission, the organization may only reduce pre-
18 miums, cost-sharing, enhance benefits, or utilize the stabiliza-
19 tion fund described in section 1854(f)(2) of such Act (42
20 U.S.C. 1395w-24(f)(2)).

21 (d) DISREGARD OF NEW RATE ANNOUNCEMENT IN AP-
22 PLYING PASS-THROUGH FOR NEW NATIONAL COVERAGE DE-
23 TERMINATIONS.—For purposes of applying section 1852(a)(5)
24 of the Social Security Act (42 U.S.C. 1395w-22(a)(5)), the an-
25 nouncement of revised rates under subsection (a) shall not be
26 treated as an announcement under section 1853(b) of such Act
27 (42 U.S.C. 1395w-23(b)).

28 **SEC. 605. REVISION OF PAYMENT RATES FOR ESRD PA-**
29 **TIENTS ENROLLED IN MEDICARE+CHOICE**
30 **PLANS.**

31 (a) IN GENERAL.—Section 1853(a)(1)(B) (42 U.S.C.
32 1395w-23(a)(1)(B)) is amended by adding at the end the fol-
33 lowing: “In establishing such rates, the Secretary shall provide
34 for appropriate adjustments to increase each rate to reflect the
35 demonstration rate (including the risk adjustment methodology
36 associated with such rate) of the social health maintenance or-
37 ganization end-stage renal disease capitation demonstrations

1 (established by section 2355 of the Deficit Reduction Act of
 2 1984, as amended by section 13567(b) of the Omnibus Budget
 3 Reconciliation Act of 1993), and shall compute such rates by
 4 taking into account such factors as renal treatment modality,
 5 age, and the underlying cause of the end-stage renal disease.”.

6 (b) EFFECTIVE DATE.—The amendment made by sub-
 7 section (a) shall apply to payments for months beginning with
 8 January 2002.

9 (c) PUBLICATION.—Not later than 6 months after the
 10 date of the enactment of this Act, the Secretary of Health and
 11 Human Services shall publish for public comment a description
 12 of the appropriate adjustments described in the last sentence
 13 of section 1853(a)(1)(B) of the Social Security Act (42 U.S.C.
 14 1395w–23(a)(1)(B)), as added by subsection (a). The Secretary
 15 shall publish such adjustments in final form by not later than
 16 July 1, 2001, so that the amendment made by subsection (a)
 17 is implemented on a timely basis consistent with subsection (b).

18 **SEC. 606. PERMITTING PREMIUM REDUCTIONS AS ADDI-**
 19 **TIONAL BENEFITS UNDER**
 20 **MEDICARE+CHOICE PLANS.**

21 (a) IN GENERAL.—

22 (1) AUTHORIZATION OF PART B PREMIUM REDUC-
 23 TIONS.—Section 1854(f)(1) (42 U.S.C. 1395w–24(f)(1)) is
 24 amended—

25 (A) by redesignating subparagraph (E) as sub-
 26 paragraph (F); and

27 (B) by inserting after subparagraph (D) the fol-
 28 lowing new subparagraph:

29 “(E) PREMIUM REDUCTIONS.—

30 “(i) IN GENERAL.—Subject to clause (ii), as
 31 part of providing any additional benefits required
 32 under subparagraph (A), a Medicare+Choice orga-
 33 nization may elect a reduction in its payments
 34 under section 1853(a)(1)(A) with respect to a
 35 Medicare+Choice plan and the Secretary shall
 36 apply such reduction to reduce the premium under

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1 section 1839 of each enrollee in such plan as pro-
 2 vided in section 1840(i).

3 “(ii) AMOUNT OF REDUCTION.—The amount
 4 of the reduction under clause (i) with respect to
 5 any enrollee in a Medicare+ Choice plan—

6 “(I) may not exceed 125 percent of the
 7 premium described under section 1839(a)(3);
 8 and

9 “(II) shall apply uniformly to each enrollee
 10 of the Medicare+ Choice plan to which such re-
 11 duction applies.”.

12 (2) CONFORMING AMENDMENTS.—

13 (A) ADJUSTMENT OF PAYMENTS TO
 14 MEDICARE+ CHOICE ORGANIZATIONS.—Section
 15 1853(a)(1)(A) (42 U.S.C. 1395w-23(a)(1)(A)) is
 16 amended by inserting “reduced by the amount of any
 17 reduction elected under section 1854(f)(1)(E) and”
 18 after “for that area,”.

19 (B) ADJUSTMENT AND PAYMENT OF PART B PRE-
 20 MIUMS.—

21 (i) ADJUSTMENT OF PREMIUMS.—Section
 22 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by
 23 striking “shall” and all that follows and inserting
 24 the following: “shall be the amount determined
 25 under paragraph (3), adjusted as required in ac-
 26 cordance with subsections (b), (c), and (f), and to
 27 reflect 80 percent of any reduction elected under
 28 section 1854(f)(1)(E).”.

29 (ii) PAYMENT OF PREMIUMS.—Section 1840
 30 (42 U.S.C. 1395s) is amended by adding at the end
 31 the following new subsection:

32 “(i) In the case of an individual enrolled in a
 33 Medicare+ Choice plan, the Secretary shall provide for nec-
 34 essary adjustments of the monthly beneficiary premium to re-
 35 flect 80 percent of any reduction elected under section
 36 1854(f)(1)(E). This premium adjustment may be provided di-
 37 rectly or as an adjustment to any social security, railroad re-

1 tirement, and civil service retirement benefits, to the extent
2 which the Secretary determines that such an adjustment is ap-
3 propriate with the concurrence of the agencies responsible for
4 the administration of such benefits.”.

5 (C) INFORMATION COMPARING PLAN PREMIUMS
6 UNDER PART C.—Section 1851(d)(4)(B) (42 U.S.C.
7 1395w-21(d)(4)(B)) is amended—

8 (i) by striking “PREMIUMS.—The” and insert-
9 ing “PREMIUMS.—

10 “(i) IN GENERAL.—The”; and

11 (ii) by adding at the end the following new
12 clause:

13 “(ii) REDUCTIONS.—The reduction in part B
14 premiums, if any.”.

15 (D) TREATMENT OF REDUCTION FOR PURPOSES
16 OF DETERMINING GOVERNMENT CONTRIBUTION UNDER
17 PART B.—Section 1844 (42 U.S.C. 1395w) is amended
18 by adding at the end the following new subsection:

19 “(c) The Secretary shall determine the Government con-
20 tribution under subparagraphs (A) and (B) of subsection (a)(1)
21 without regard to any premium reduction resulting from an
22 election under section 1854(f)(1)(E).”.

23 (b) EFFECTIVE DATE.—The amendments made by sub-
24 section (a) shall apply to years beginning with 2002.

25 **SEC. 607. FULL IMPLEMENTATION OF RISK ADJUST-**
26 **MENT FOR CONGESTIVE HEART FAILURE**
27 **ENROLLEES FOR 2001.**

28 (a) IN GENERAL.—Section 1853(a)(3)(C) (42 U.S.C.
29 1395w-23(a)(3)(C)) is amended—

30 (1) in clause (ii), by striking “Such risk adjustment”
31 and inserting “Except as provided in clause (iii), such risk
32 adjustment”; and

33 (2) by adding at the end the following new clause:

34 “(iii) FULL IMPLEMENTATION OF RISK AD-
35 JUSTMENT FOR CONGESTIVE HEART FAILURE EN-
36 ROLLEES FOR 2001.—

1 “(I) EXEMPTION FROM PHASE-IN.—Sub-
2 ject to subclause (II), the Secretary shall fully
3 implement the risk adjustment methodology de-
4 scribed in clause (i) with respect to each indi-
5 vidual who has had a qualifying congestive
6 heart failure inpatient diagnosis (as determined
7 by the Secretary under such risk adjustment
8 methodology) during the period beginning on
9 July 1, 1999, and ending on June 30, 2000,
10 and who is enrolled in a coordinated care plan
11 that is the only coordinated care plan offered
12 on January 1, 2001, in the service area of the
13 individual.

14 “(II) PERIOD OF APPLICATION.—Sub-
15 clause (I) shall only apply during the 1-year pe-
16 riod beginning on January 1, 2001.”.

17 (b) EXCLUSION FROM DETERMINATION OF THE BUDGET
18 NEUTRALITY FACTOR.—Section 1853(c)(5) (42 U.S.C. 1395w-
19 23(c)(5)) is amended by striking “subsection (i)” and inserting
20 “subsections (a)(3)(C)(iii) and (i)”.

21 **SEC. 608. EXPANSION OF APPLICATION OF**
22 **MEDICARE+CHOICE NEW ENTRY BONUS.**

23 (a) IN GENERAL.—Section 1853(i)(1) (42 U.S.C. 1395w-
24 23(i)(1)) is amended in the matter preceding subparagraph (A)
25 by inserting “, or filed notice with the Secretary as of October
26 3, 2000, that they will not be offering such a plan as of Janu-
27 ary 1, 2001” after “January 1, 2000”.

28 (b) EFFECTIVE DATE.—The amendment made by sub-
29 section (a) shall apply as if included in the enactment of
30 BBRA.

31 **SEC. 609. REPORT ON INCLUSION OF CERTAIN COSTS OF**
32 **THE DEPARTMENT OF VETERANS AFFAIRS**
33 **AND MILITARY FACILITY SERVICES IN CAL-**
34 **CULATING MEDICARE+CHOICE PAYMENT**
35 **RATES.**

36 The Secretary of Health and Human Services shall report
37 to Congress by not later than January 1, 2003, on a method
38 to phase-in the costs of military facility services furnished by

1 the Department of Veterans Affairs, and the costs of military
 2 facility services furnished by the Department of Defense, to
 3 medicare-eligible beneficiaries in the calculation of an area's
 4 Medicare+ Choice capitation payment. Such report shall include
 5 on a county-by-county basis—

6 (1) the actual or estimated cost of such services to
 7 medicare-eligible beneficiaries;

8 (2) the change in Medicare+ Choice capitation pay-
 9 ment rates if such costs are included in the calculation of
 10 payment rates;

11 (3) one or more proposals for the implementation of
 12 payment adjustments to Medicare+ Choice plans in coun-
 13 ties where the payment rate has been affected due to the
 14 failure to calculate the cost of such services to medicare-
 15 eligible beneficiaries; and

16 (4) a system to ensure that when a Medicare+ Choice
 17 enrollee receives covered services through a facility of the
 18 Department of Veterans Affairs or the Department of De-
 19 fense there is an appropriate payment recovery to the medi-
 20 care program under title XVIII of the Social Security Act.

21 **Subtitle B—Other Medicare+Choice** 22 **Reforms**

23 **SEC. 611. PAYMENT OF ADDITIONAL AMOUNTS FOR NEW** 24 **BENEFITS COVERED DURING A CONTRACT** 25 **TERM.**

26 (a) IN GENERAL.—Section 1853(c)(7) (42 U.S.C. 1395w-
 27 23(c)(7)) is amended to read as follows:

28 “(7) ADJUSTMENT FOR NATIONAL COVERAGE DETER-
 29 MINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If
 30 the Secretary makes a determination with respect to cov-
 31 erage under this title or there is a change in benefits re-
 32 quired to be provided under this part that the Secretary
 33 projects will result in a significant increase in the costs to
 34 Medicare+ Choice of providing benefits under contracts
 35 under this part (for periods after any period described in
 36 section 1852(a)(5)), the Secretary shall adjust appro-
 37 priately the payments to such organizations under this

1 part. Such projection and adjustment shall be based on an
 2 analysis by the Chief Actuary of the Health Care Financing
 3 Administration of the actuarial costs associated with the
 4 new benefits.”.

5 (b) CONFORMING AMENDMENT.—Section 1852(a)(5) (42
 6 U.S.C. 1395w-22(a)(5)) is amended—

7 (1) in the heading, by inserting “AND LEGISLATIVE
 8 CHANGES IN BENEFITS” after “NATIONAL COVERAGE DE-
 9 TERMINATIONS”;

10 (2) by inserting “or legislative change in benefits re-
 11 quired to be provided under this part” after “national cov-
 12 erage determination”;

13 (3) in subparagraph (A), by inserting “or legislative
 14 change in benefits” after “such determination”;

15 (4) in subparagraph (B), by inserting “or legislative
 16 change” after “if such coverage determination”; and

17 (5) by adding at the end the following:

18 “The projection under the previous sentence shall be based
 19 on an analysis by the Chief Actuary of the Health Care Fi-
 20 nancing Administration of the actuarial costs associated
 21 with the coverage determination or legislative change in
 22 benefits.”.

23 (c) EFFECTIVE DATE.—The amendments made by this
 24 section are effective on the date of the enactment of this Act
 25 and apply to national coverage determinations and legislative
 26 changes in benefits occurring on or after such date.

27 **SEC. 612. RESTRICTION ON IMPLEMENTATION OF SIG-**
 28 **NIFICANT NEW REGULATORY REQUIRE-**
 29 **MENTS MIDYEAR.**

30 (a) IN GENERAL.—Section 1856(b) (42 U.S.C. 1395w-
 31 26(b)) is amended by adding at the end the following new para-
 32 graph:

33 “(4) PROHIBITION OF MIDYEAR IMPLEMENTATION OF
 34 SIGNIFICANT NEW REGULATORY REQUIREMENTS.—The
 35 Secretary may not implement, other than at the beginning
 36 of a calendar year, regulations under this section that im-

1 pose new, significant regulatory requirements on a
2 Medicare+ Choice organization or plan.”.

3 (b) EFFECTIVE DATE.—The amendment made by sub-
4 section (a) takes effect on the date of the enactment of this
5 Act.

6 **SEC. 613. TIMELY APPROVAL OF MARKETING MATERIAL**
7 **THAT FOLLOWS MODEL MARKETING LAN-**
8 **GUAGE.**

9 (a) IN GENERAL.—Section 1851(h) (42 U.S.C. 1395w-
10 21(h)) is amended—

11 (1) in paragraph (1)(A), by inserting “(or 10 days in
12 the case described in paragraph (5))” after “45 days”; and

13 (2) by adding at the end the following new paragraph:

14 “(5) SPECIAL TREATMENT OF MARKETING MATERIAL
15 FOLLOWING MODEL MARKETING LANGUAGE.—In the case
16 of marketing material of an organization that uses, without
17 modification, proposed model language specified by the Sec-
18 retary, the period specified in paragraph (1)(A) shall be re-
19 duced from 45 days to 10 days.”.

20 (b) EFFECTIVE DATE.—The amendments made by sub-
21 section (a) apply to marketing material submitted on or after
22 January 1, 2001.

23 **SEC. 614. AVOIDING DUPLICATIVE REGULATION.**

24 (a) IN GENERAL.—Section 1856(b)(3)(B) (42 U.S.C.
25 1395w-26(b)(3)(B)) is amended—

26 (1) in clause (i), by inserting “(including cost-sharing
27 requirements)” after “Benefit requirements”; and

28 (2) by adding at the end the following new clause:

29 “(iv) Requirements relating to marketing ma-
30 terials and summaries and schedules of benefits re-
31 garding a Medicare+ Choice plan.”.

32 (b) EFFECTIVE DATE.—The amendments made by sub-
33 section (a) take effect on the date of the enactment of this Act.

34 **SEC. 615. ELECTION OF UNIFORM LOCAL COVERAGE**
35 **POLICY FOR MEDICARE+CHOICE PLAN COV-**
36 **ERING MULTIPLE LOCALITIES.**

37 Section 1852(a)(2) (42 U.S.C. 1395w-22(a)(2)) is amend-
38 ed by adding at the end the following new subparagraph:

1 “(C) ELECTION OF UNIFORM COVERAGE POL-
2 ICY.—In the case of a Medicare+ Choice organization
3 that offers a Medicare+ Choice plan in an area in which
4 more than one local coverage policy is applied with re-
5 spect to different parts of the area, the organization
6 may elect to have the local coverage policy for the part
7 of the area that is most beneficial to Medicare+ Choice
8 enrollees (as identified by the Secretary) apply with re-
9 spect to all Medicare+ Choice enrollees enrolled in the
10 plan.”.

11 **SEC. 616. ELIMINATING HEALTH DISPARITIES IN**
12 **MEDICARE+CHOICE PROGRAM.**

13 (a) QUALITY ASSURANCE PROGRAM FOCUS ON RACIAL
14 AND ETHNIC MINORITIES.—Subparagraphs (A) and (B) of sec-
15 tion 1852(e)(2) (42 U.S.C. 1395w-22(e)(2)) are each amended
16 by adding at the end the following:

17 “Such program shall include a separate focus (with re-
18 spect to all the elements described in this subpara-
19 graph) on racial and ethnic minorities.”.

20 (b) REPORT.—Section 1852(e) (42 U.S.C. 1395w-22(e))
21 is amended by adding at the end the following new paragraph:

22 “(5) REPORT TO CONGRESS.—

23 “(A) IN GENERAL.—Not later than 2 years after
24 the date of the enactment of this paragraph, and bien-
25 nially thereafter, the Secretary shall submit to Con-
26 gress a report regarding how quality assurance pro-
27 grams conducted under this subsection focus on racial
28 and ethnic minorities.

29 “(B) CONTENTS OF REPORT.—Each such report
30 shall include the following:

31 “(i) A description of the means by which such
32 programs focus on such racial and ethnic minori-
33 ties.

34 “(ii) An evaluation of the impact of such pro-
35 grams on eliminating health disparities and on im-
36 proving health outcomes, continuity and coordina-

1 tion of care, management of chronic conditions,
2 and consumer satisfaction.

3 “(iii) Recommendations on ways to reduce
4 clinical outcome disparities among racial and ethnic
5 minorities.”.

6 **SEC. 617. MEDICARE+CHOICE PROGRAM COMPAT-**
7 **IBILITY WITH EMPLOYER OR UNION GROUP**
8 **HEALTH PLANS.**

9 (a) IN GENERAL.—Section 1857 (42 U.S.C. 1395w–27) is
10 amended by adding at the end the following new subsection:

11 “(i) MEDICARE+ CHOICE PROGRAM COMPATIBILITY WITH
12 EMPLOYER OR UNION GROUP HEALTH PLANS.—To facilitate
13 the offering of Medicare+ Choice plans under contracts between
14 Medicare+ Choice organizations and employers, labor organiza-
15 tions, or the trustees of a fund established by 1 or more em-
16 ployers or labor organizations (or combination thereof) to fur-
17 nish benefits to the entity’s employees, former employees (or
18 combination thereof) or members or former members (or com-
19 bination thereof) of the labor organizations, the Secretary may
20 waive or modify requirements that hinder the design of, the of-
21 fering of, or the enrollment in such Medicare+ Choice plans.”.

22 (b) EFFECTIVE DATE.—The amendment made by sub-
23 section (a) applies with respect to years beginning with 2001.

24 **SEC. 618. SPECIAL MEDIGAP ENROLLMENT ANTI-**
25 **DISCRIMINATION PROVISION FOR CERTAIN**
26 **BENEFICIARIES.**

27 (a) DISENROLLMENT WINDOW IN ACCORDANCE WITH
28 BENEFICIARY’S CIRCUMSTANCE.—Section 1882(s)(3) (42
29 U.S.C. 1395ss(s)(3)) is amended—

30 (1) in subparagraph (A), in the matter following
31 clause (iii), by striking “, subject to subparagraph (E),
32 seeks to enroll under the policy not later than 63 days after
33 the date of the termination of enrollment described in such
34 subparagraph” and inserting “seeks to enroll under the
35 policy during the period specified in subparagraph (E)”;
36 and

37 (2) by striking subparagraph (E) and inserting the fol-
38 lowing new subparagraph:

1 “(E) For purposes of subparagraph (A), the time period
2 specified in this subparagraph is—

3 “(i) in the case of an individual described in subpara-
4 graph (B)(i), the period beginning on the date the indi-
5 vidual receives a notice of termination or cessation of all
6 supplemental health benefits (or, if no such notice is re-
7 ceived, notice that a claim has been denied because of such
8 a termination or cessation) and ending on the date that is
9 63 days after the applicable notice;

10 “(ii) in the case of an individual described in clause
11 (ii), (iii), (v), or (vi) of subparagraph (B) whose enrollment
12 is terminated involuntarily, the period beginning on the
13 date that the individual receives a notice of termination and
14 ending on the date that is 63 days after the date the appli-
15 cable coverage is terminated;

16 “(iii) in the case of an individual described in subpara-
17 graph (B)(iv)(I), the period beginning on the earlier of (I)
18 the date that the individual receives a notice of termi-
19 nation, a notice of the issuer’s bankruptcy or insolvency, or
20 other such similar notice, if any, and (II) the date that the
21 applicable coverage is terminated, and ending on the date
22 that is 63 days after the date the coverage is terminated;

23 “(iv) in the case of an individual described in clause
24 (ii), (iii), (iv)(II), (iv)(III), (v), or (vi) of subparagraph (B)
25 who disenrolls voluntarily, the period beginning on the date
26 that is 60 days before the effective date of the
27 disenrollment and ending on the date that is 63 days after
28 such effective date; and

29 “(v) in the case of an individual described in subpara-
30 graph (B) but not described in the preceding provisions of
31 this subparagraph, the period beginning on the effective
32 date of the disenrollment and ending on the date that is
33 63 days after such effective date.”.

34 (b) EXTENDED MEDIGAP ACCESS FOR INTERRUPTED
35 TRIAL PERIODS.—Section 1882(s)(3) (42 U.S.C.
36 1395ss(s)(3)), as amended by subsection (a), is further amend-
37 ed by adding at the end the following new subparagraph:

1 “(F)(i) Subject to clause (ii), for purposes of this
2 paragraph—

3 “(I) in the case of an individual described in subpara-
4 graph (B)(v) (or deemed to be so described, pursuant to
5 this subparagraph) whose enrollment with an organization
6 or provider described in subclause (II) of such subpara-
7 graph is involuntarily terminated within the first 12
8 months of such enrollment, and who, without an inter-
9 vening enrollment, enrolls with another such organization
10 or provider, such subsequent enrollment shall be deemed to
11 be an initial enrollment described in such subparagraph;
12 and

13 “(II) in the case of an individual described in clause
14 (vi) of subparagraph (B) (or deemed to be so described,
15 pursuant to this subparagraph) whose enrollment with a
16 plan or in a program described in such clause is involun-
17 tarily terminated within the first 12 months of such enroll-
18 ment, and who, without an intervening enrollment, enrolls
19 in another such plan or program, such subsequent enroll-
20 ment shall be deemed to be an initial enrollment described
21 in such clause.

22 “(ii) For purposes of clauses (v) and (vi) of subparagraph
23 (B), no enrollment of an individual with an organization or pro-
24 vider described in clause (v)(II), or with a plan or in a program
25 described in clause (vi), may be deemed to be an initial enroll-
26 ment under this clause after the 2-year period beginning on the
27 date on which the individual first enrolled with such an organi-
28 zation, provider, plan, or program.”.

29 **SEC. 619. RESTORING EFFECTIVE DATE OF ELECTIONS**
30 **AND CHANGES OF ELECTIONS OF**
31 **MEDICARE+CHOICE PLANS.**

32 (a) OPEN ENROLLMENT.—Section 1851(f)(2) (42 U.S.C.
33 1395w–21(f)(2)) is amended by striking “, except that if such
34 election or change is made after the 10th day of any calendar
35 month, then the election or change shall not take effect until
36 the first day of the second calendar month following the date
37 on which the election or change is made”.

1 (b) EFFECTIVE DATE.—The amendment made by this sec-
2 tion shall apply to elections and changes of coverage made on
3 or after January 1, 2001.

4 **SEC. 620. PERMITTING ESRD BENEFICIARIES TO EN-**
5 **ROLL IN ANOTHER MEDICARE+CHOICE PLAN**
6 **IF THE PLAN IN WHICH THEY ARE EN-**
7 **ROLLED IS TERMINATED.**

8 (a) IN GENERAL.—Section 1851(a)(3)(B) (42 U.S.C.
9 1395w-21(a)(3)(B)) is amended by striking “except that” and
10 all that follows and inserting the following: “except that—

11 “(i) an individual who develops end-stage renal
12 disease while enrolled in a Medicare+ Choice plan
13 may continue to be enrolled in that plan; and

14 “(ii) in the case of such an individual who is
15 enrolled in a Medicare+ Choice plan under clause
16 (i) (or subsequently under this clause), if the en-
17 rollment is discontinued under circumstances de-
18 scribed in section 1851(e)(4)(A), then the indi-
19 vidual will be treated as a ‘Medicare+ Choice eligi-
20 ble individual’ for purposes of electing to continue
21 enrollment in another Medicare+ Choice plan.”.

22 (b) EFFECTIVE DATE.—

23 (1) IN GENERAL.—The amendment made by sub-
24 section (a) shall apply to terminations and discontinuations
25 occurring on or after the date of the enactment of this Act.

26 (2) APPLICATION TO PRIOR PLAN TERMINATIONS.—
27 Clause (ii) of section 1851(a)(3)(B) of the Social Security
28 Act (as inserted by subsection (a)) also shall apply to indi-
29 viduals whose enrollment in a Medicare+ Choice plan was
30 terminated or discontinued after December 31, 1998, and
31 before the date of the enactment of this Act. In applying
32 this paragraph, such an individual shall be treated, for pur-
33 poses of part C of title XVIII of the Social Security Act,
34 as having discontinued enrollment in such a plan as of the
35 date of the enactment of this Act.

1 **SEC. 621. PROVIDING CHOICE FOR SKILLED NURSING**
2 **FACILITY SERVICES UNDER THE**
3 **MEDICARE+CHOICE PROGRAM.**

4 (a) IN GENERAL.—Section 1852 (42 U.S.C. 1395w-22) is
5 amended by adding at the end the following new subsection:

6 “(l) RETURN TO HOME SKILLED NURSING FACILITIES
7 FOR COVERED POST-HOSPITAL EXTENDED CARE SERVICES.—

8 “(1) ENSURING RETURN TO HOME SNF.—

9 “(A) IN GENERAL.—In providing coverage of post-
10 hospital extended care services, a Medicare+ Choice
11 plan shall provide for such coverage through a home
12 skilled nursing facility if the following conditions are
13 met:

14 “(i) ENROLLEE ELECTION.—The enrollee
15 elects to receive such coverage through such facil-
16 ity.

17 “(ii) SNF AGREEMENT.—The facility has a
18 contract with the Medicare+ Choice organization
19 for the provision of such services, or the facility
20 agrees to accept substantially similar payment
21 under the same terms and conditions that apply to
22 similarly situated skilled nursing facilities that are
23 under contract with the Medicare+ Choice organiza-
24 tion for the provision of such services and through
25 which the enrollee would otherwise receive such
26 services.

27 “(B) MANNER OF PAYMENT TO HOME SNF.—The
28 organization shall provide payment to the home skilled
29 nursing facility consistent with the contract or the
30 agreement described in subparagraph (A)(ii), as the
31 case may be.

32 “(2) NO LESS FAVORABLE COVERAGE.—The coverage
33 provided under paragraph (1) (including scope of services,
34 cost-sharing, and other criteria of coverage) shall be no less
35 favorable to the enrollee than the coverage that would be
36 provided to the enrollee with respect to a skilled nursing fa-

1 cility the post-hospital extended care services of which are
2 otherwise covered under the Medicare+ Choice plan.

3 “(3) RULE OF CONSTRUCTION.—Nothing in this sub-
4 section shall be construed to do the following:

5 “(A) To require coverage through a skilled nursing
6 facility that is not otherwise qualified to provide bene-
7 fits under part A for medicare beneficiaries not enrolled
8 in a Medicare+ Choice plan.

9 “(B) To prevent a skilled nursing facility from re-
10 fusing to accept, or imposing conditions upon the ac-
11 ceptance of, an enrollee for the receipt of post-hospital
12 extended care services.

13 “(4) DEFINITIONS.—In this subsection:

14 “(A) HOME SKILLED NURSING FACILITY.—The
15 term ‘home skilled nursing facility’ means, with respect
16 to an enrollee who is entitled to receive post-hospital
17 extended care services under a Medicare+ Choice plan,
18 any of the following skilled nursing facilities:

19 “(i) SNF RESIDENCE AT TIME OF ADMIS-
20 SION.—The skilled nursing facility in which the en-
21 rollee resided at the time of admission to the hos-
22 pital preceding the receipt of such post-hospital ex-
23 tended care services.

24 “(ii) SNF IN CONTINUING CARE RETIREMENT
25 COMMUNITY.—A skilled nursing facility that is pro-
26 viding such services through a continuing care re-
27 tirement community (as defined in subparagraph
28 (B)) which provided residence to the enrollee at the
29 time of such admission.

30 “(iii) SNF RESIDENCE OF SPOUSE AT TIME OF
31 DISCHARGE.—The skilled nursing facility in which
32 the spouse of the enrollee is residing at the time of
33 discharge from such hospital.

34 “(B) CONTINUING CARE RETIREMENT COMMU-
35 NITY.—The term ‘continuing care retirement commu-
36 nity’ means, with respect to an enrollee in a
37 Medicare+ Choice plan, an arrangement under which

1 housing and health-related services are provided (or ar-
2 ranged) through an organization for the enrollee under
3 an agreement that is effective for the life of the en-
4 rollee or for a specified period.”.

5 (b) EFFECTIVE DATE.—The amendment made by sub-
6 section (a) applies with respect to contracts entered into or re-
7 newed on or after the date of the enactment of this Act.

8 (c) MEDPAC STUDY.—

9 (1) STUDY.—The Medicare Payment Advisory Com-
10 mission shall conduct a study analyzing the effects of the
11 amendment made by subsection (a) on Medicare+ Choice
12 organizations. In conducting such study, the Commission
13 shall examine the effects (if any) such amendment has had
14 on—

15 (A) the scope of additional benefits provided under
16 the Medicare+ Choice program;

17 (B) the administrative and other costs incurred by
18 Medicare+ Choice organizations;

19 (C) the contractual relationships between such or-
20 ganizations and skilled nursing facilities.

21 (2) REPORT.—Not later than 2 years after the date of
22 the enactment of this Act, the Commission shall submit to
23 Congress a report on the study conducted under paragraph
24 (1).

25 **SEC. 622. PROVIDING FOR ACCOUNTABILITY OF**
26 **MEDICARE+CHOICE PLANS.**

27 (a) MANDATORY REVIEW OF ACR SUBMISSIONS BY THE
28 CHIEF ACTUARY OF THE HEALTH CARE FINANCING ADMINIS-
29 TRATION.—Section 1854(a)(5)(A) (42 U.S.C. 1395w-
30 24(a)(5)(A)) is amended—

31 (1) by striking “value” and inserting “values”; and

32 (2) by adding at the end the following: “The Chief Ac-
33 tuary of the Health Care Financing Administration shall
34 review the actuarial assumptions and data used by the
35 Medicare+ Choice organization with respect to such rates,
36 amounts, and values so submitted to determine the appro-
37 priateness of such assumptions and data.”.

1 (b) EFFECTIVE DATE.—The amendment made by sub-
2 section (a) applies to submissions made on or after January 1,
3 2001.

4 **Subtitle C—Other Managed Care** 5 **Reforms**

6 **SEC. 631. 1-YEAR EXTENSION OF SOCIAL HEALTH MAIN-** 7 **TENANCE ORGANIZATION (SHMO) DEM-** 8 **ONSTRATION PROJECT.**

9 Section 4018(b)(1) of the Omnibus Budget Reconciliation
10 Act of 1987, as amended by section 531(a)(1) of BBRA (113
11 Stat. 1501A–388), is amended by striking “18 months” and in-
12 sserting “30 months”.

13 **SEC. 632. REVISED TERMS AND CONDITIONS FOR EX-** 14 **TENSION OF MEDICARE COMMUNITY NURS-** 15 **ING ORGANIZATION (CNO) DEMONSTRATION** 16 **PROJECT.**

17 (a) IN GENERAL.—Section 532 of BBRA (113 Stat.
18 1501A–388) is amended—

19 (1) in subsection (a), by striking the second sentence;
20 and

21 (2) by striking subsection (b) and inserting the fol-
22 lowing new subsection:

23 “(b) TERMS AND CONDITIONS.—

24 “(1) JANUARY THROUGH SEPTEMBER 2000.—For the
25 9-month period beginning with January 2000, any such
26 demonstration project shall be conducted under the same
27 terms and conditions as applied to such demonstration dur-
28 ing 1999.

29 “(2) OCTOBER 2000 THROUGH DECEMBER 2001.—For
30 the 15-month period beginning with October 2000, any
31 such demonstration project shall be conducted under the
32 same terms and conditions as applied to such demonstra-
33 tion during 1999, except that the following modifications
34 shall apply:

35 “(A) BASIC CAPITATION RATE.—The basic capita-
36 tion rate paid for services covered under the project

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1 (other than case management services) per enrollee per
2 month and furnished during—

3 “(i) the period beginning with October 1,
4 2000, and ending with December 31, 2000, shall be
5 determined by actuarially adjusting the actual capi-
6 tation rate paid for such services in 1999 for infla-
7 tion, utilization, and other changes to the CNO
8 service package, and by reducing such adjusted
9 capitation rate by 10 percent in the case of the
10 demonstration sites located in Arizona, Minnesota,
11 and Illinois, and 15 percent for the demonstration
12 site located in New York; and

13 “(ii) 2001 shall be determined by actuarially
14 adjusting the capitation rate determined under
15 clause (i) for inflation, utilization, and other
16 changes to the CNO service package.

17 “(B) TARGETED CASE MANAGEMENT FEE.—Effec-
18 tive October 1, 2000—

19 “(i) the case management fee per enrollee per
20 month for—

21 “(I) the period described in subparagraph
22 (A)(i) shall be determined by actuarially ad-
23 justing the case management fee for 1999 for
24 inflation; and

25 “(II) 2001 shall be determined by actuari-
26 ally adjusting the amount determined under
27 subclause (I) for inflation; and

28 “(ii) such case management fee shall be paid
29 only for enrollees who are classified as moderately
30 frail or frail pursuant to criteria established by the
31 Secretary.

32 “(C) GREATER UNIFORMITY IN CLINICAL FEA-
33 TURES AMONG SITES.—Each project shall implement
34 for each site—

35 “(i) protocols for periodic telephonic contact
36 with enrollees based on—

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1 “(I) the results of such standardized writ-
2 ten health assessment; and

3 “(II) the application of appropriate care
4 planning approaches;

5 “(ii) disease management programs for tar-
6 geted diseases (such as congestive heart failure, ar-
7 thritis, diabetes, and hypertension) that are highly
8 prevalent in the enrolled populations;

9 “(iii) systems and protocols to track enrollees
10 through hospitalizations, including pre-admission
11 planning, concurrent management during inpatient
12 hospital stays, and post-discharge assessment, plan-
13 ning, and follow-up; and

14 “(iv) standardized patient educational mate-
15 rials for specified diseases and health conditions.

16 “(D) QUALITY IMPROVEMENT.—Each project shall
17 implement at each site once during the 15-month
18 period—

19 “(i) enrollee satisfaction surveys; and

20 “(ii) reporting on specified quality indicators
21 for the enrolled population.

22 “(c) EVALUATION.—

23 “(1) PRELIMINARY REPORT.—Not later than July 1,
24 2001, the Secretary of Health and Human Services shall
25 submit to the Committees on Ways and Means and Com-
26 merce of the House of Representatives and the Committee
27 on Finance of the Senate a preliminary report that—

28 “(A) evaluates such demonstration projects for the
29 period beginning July 1, 1997, and ending December
30 31, 1999, on a site-specific basis with respect to the
31 impact on per beneficiary spending, specific health uti-
32 lization measures, and enrollee satisfaction; and

33 “(B) includes a similar evaluation of such projects
34 for the portion of the extension period that occurs after
35 September 30, 2000.

36 “(2) FINAL REPORT.—The Secretary shall submit a
37 final report to such Committees on such demonstration

1 projects not later than July 1, 2002. Such report shall in-
2 clude the same elements as the preliminary report required
3 by paragraph (1), but for the period after December 31,
4 1999.

5 “(3) METHODOLOGY FOR SPENDING COMPARISONS.—
6 Any evaluation of the impact of the demonstration projects
7 on per beneficiary spending included in such reports shall
8 include a comparison of—

9 “(A) data for all individuals who—

10 “(i) were enrolled in such demonstration
11 projects as of the first day of the period under eval-
12 uation; and

13 “(ii) were enrolled for a minimum of 6 months
14 thereafter; with

15 “(B) data for a matched sample of individuals who
16 are enrolled under part B of title XVIII of the Social
17 Security Act and are not enrolled in such a project, or
18 in a Medicare+ Choice plan under part C of such title,
19 a plan offered by an eligible organization under section
20 1876 of such Act, or a health care prepayment plan
21 under section 1833(a)(1)(A) of such Act.”.

22 (b) EFFECTIVE DATE.—The amendments made by sub-
23 section (a) shall be effective as if included in the enactment of
24 section 532 of BBRA (113 Stat. 1501A-388).

25 **SEC. 633. EXTENSION OF MEDICARE MUNICIPAL**
26 **HEALTH SERVICES DEMONSTRATION**
27 **PROJECTS.**

28 Section 9215(a) of the Consolidated Omnibus Budget Rec-
29 onciliation Act of 1985 (42 U.S.C. 1395b-1 note), as amended
30 by section 6135 of the Omnibus Budget Reconciliation Act of
31 1989, section 13557 of the Omnibus Budget Reconciliation Act
32 of 1993, section 4017 of BBA, and section 534 of BBRA (113
33 Stat. 1501A-390), is amended by striking “December 31,
34 2002” and inserting “December 31, 2004”.

1 **SEC. 634. SERVICE AREA EXPANSION FOR MEDICARE**
 2 **COST CONTRACTS DURING TRANSITION PE-**
 3 **RIOD.**

4 Section 1876(h)(5) (42 U.S.C. 1395mm(h)(5)) is
 5 amended—

6 (1) by redesignating subparagraph (B) as subpara-
 7 graph (C); and

8 (2) by inserting after subparagraph (A), the following
 9 new subparagraph:

10 “(B) Subject to subparagraph (C), the Secretary shall ap-
 11 prove an application for a modification to a reasonable cost
 12 contract under this section in order to expand the service area
 13 of such contract if—

14 “(i) such application is submitted to the Secretary on
 15 or before September 1, 2003; and

16 “(ii) the Secretary determines that the organization
 17 with the contract continues to meet the requirements appli-
 18 cable to such organizations and contracts under this sec-
 19 tion.”.

20 **TITLE VII—MEDICAID**

21 **SEC. 701. DSH PAYMENTS.**

22 (a) MODIFICATIONS TO DSH ALLOTMENTS.—

23 (1) INCREASED ALLOTMENTS FOR FISCAL YEARS 2001
 24 AND 2002.—

25 (A) IN GENERAL.—Section 1923(f) (42 U.S.C.
 26 1396r-4(f)) is amended—

27 (i) in paragraph (2), by striking “The DSH
 28 allotment” and inserting “Subject to paragraph
 29 (4), the DSH allotment”;

30 (ii) by redesignating paragraph (4) as para-
 31 graph (6); and

32 (iii) by inserting after paragraph (3) the fol-
 33 lowing new paragraph:

34 “(4) SPECIAL RULE FOR FISCAL YEARS 2001 AND
 35 2002.—

36 “(A) IN GENERAL.—Notwithstanding paragraph
 37 (2), the DSH allotment for any State for—

1 “(i) fiscal year 2001, shall be the DSH allot-
2 ment determined under paragraph (2) for fiscal
3 year 2000 increased, subject to subparagraph (B)
4 and paragraph (5), by the percentage change in the
5 consumer price index for all urban consumers (all
6 items; U.S. city average) for fiscal year 2000; and

7 “(ii) fiscal year 2002, shall be the DSH allot-
8 ment determined under clause (i) increased, subject
9 to subparagraph (B) and paragraph (5), by the
10 percentage change in the consumer price index for
11 all urban consumers (all items; U.S. city average)
12 for fiscal year 2001.

13 “(B) LIMITATION.—Subparagraph (B) of para-
14 graph (3) shall apply to subparagraph (A) of this para-
15 graph in the same manner as that subparagraph (B)
16 applies to paragraph (3)(A).

17 “(C) NO APPLICATION TO ALLOTMENTS AFTER
18 FISCAL YEAR 2002.—The DSH allotment for any State
19 for fiscal year 2003 or any succeeding fiscal year shall
20 be determined under paragraph (3) without regard to
21 the DSH allotments determined under subparagraph
22 (A) of this paragraph.”.

23 (2) SPECIAL RULE FOR MEDICAID DSH ALLOTMENT
24 FOR EXTREMELY LOW DSH STATES.—

25 (A) IN GENERAL.—Section 1923(f) (42 U.S.C.
26 1396r-4(f)), as amended by paragraph (1), is amended
27 by inserting after paragraph (4) the following new
28 paragraph:

29 “(5) SPECIAL RULE FOR EXTREMELY LOW DSH
30 STATES.—In the case of a State in which the total expendi-
31 tures under the State plan (including Federal and State
32 shares) for disproportionate share hospital adjustments
33 under this section for fiscal year 1999, as reported to the
34 Administrator of the Health Care Financing Administra-
35 tion as of August 31, 2000, is greater than 0 but less than
36 1 percent of the State’s total amount of expenditures under
37 the State plan for medical assistance during the fiscal year,

1 the DSH allotment for fiscal year 2001 shall be increased
2 to 1 percent of the State's total amount of expenditures
3 under such plan for such assistance during such fiscal year.
4 In subsequent fiscal years, such increased allotment is sub-
5 ject to an increase for inflation as provided in paragraph
6 (3)(A).”.

7 (B) CONFORMING AMENDMENT.—Section
8 1923(f)(3)(A) (42 U.S.C. 1396r-4(f)(3)(A)) is amend-
9 ed by inserting “and paragraph (5)” after “subpara-
10 graph (B)”.

11 (3) EFFECTIVE DATE.—The amendments made by
12 paragraphs (1) and (2) take effect on the date the final
13 regulation required under section 705(a) (relating to the
14 application of an aggregate upper payment limit test for
15 State medicaid spending for inpatient hospital services, out-
16 patient hospital services, nursing facility services, inter-
17 mediate care facility services for the mentally retarded, and
18 clinic services provided by government facilities that are not
19 State-owned or operated facilities) is published in the Fed-
20 eral Register.

21 (b) ASSURING IDENTIFICATION OF MEDICAID MANAGED
22 CARE PATIENTS.—

23 (1) IN GENERAL.—Section 1932 (42 U.S.C. 1396u-2)
24 is amended by adding at the end the following new sub-
25 section:

26 “(g) IDENTIFICATION OF PATIENTS FOR PURPOSES OF
27 MAKING DSH PAYMENTS.—Each contract with a managed
28 care entity under section 1903(m) or under section 1905(t)(3)
29 shall require the entity either—

30 “(1) to report to the State information necessary to
31 determine the hospital services provided under the contract
32 (and the identity of hospitals providing such services) for
33 purposes of applying sections 1886(d)(5)(F) and 1923; or

34 “(2) to include a sponsorship code in the identification
35 card issued to individuals covered under this title in order
36 that a hospital may identify a patient as being entitled to
37 benefits under this title.”.

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1 (2) CLARIFICATION OF COUNTING MANAGED CARE
2 MEDICAID PATIENTS.—Section 1923 (42 U.S.C. 1396r-4)
3 is amended—

4 (A) in subsection (a)(2)(D), by inserting after
5 “the proportion of low-income and medicaid patients”
6 the following: “(including such patients who receive
7 benefits through a managed care entity)”;

8 (B) in subsection (b)(2), by inserting after “a
9 State plan approved under this title in a period” the
10 following: “(regardless of whether such patients receive
11 medical assistance on a fee-for-service basis or through
12 a managed care entity)”;

13 (C) in subsection (b)(3)(A)(i), by inserting after
14 “under a State plan under this title” the following:
15 “(regardless of whether the services were furnished on
16 a fee-for-service basis or through a managed care enti-
17 ty)”.

18 (3) EFFECTIVE DATES.—

19 (A) The amendment made by paragraph (1) ap-
20 plies to contracts as of January 1, 2001.

21 (B) The amendments made by paragraph (2)
22 apply to payments made on or after January 1, 2001.

23 (c) APPLICATION OF MEDICAID DSH TRANSITION RULE
24 TO PUBLIC HOSPITALS IN ALL STATES.—

25 (1) IN GENERAL.—During the period described in
26 paragraph (3), with respect to a State, section 4721(e) of
27 the Balanced Budget Act of 1997 (Public Law 105-33;
28 111 Stat. 514), as amended by section 607 of BBRA (113
29 Stat. 1501A-321) shall be applied as though—

30 (A) “September 30, 2002” were substituted for
31 “July 1, 1997” each place it appears;

32 (B) “hospitals owned or operated by a State (as
33 defined for purposes of title XIX of such Act), or by
34 an instrumentality or a unit of government within a
35 State (as so defined)” were substituted for “the State
36 of California”;

1 (C) paragraph (3) were redesignated as paragraph
2 (4);

3 (D) “and” were omitted from the end of para-
4 graph (2); and

5 (E) the following new paragraph were inserted
6 after paragraph (2):

7 “(3) ‘(as defined in subparagraph (B) but without re-
8 gard to clause (ii) of that subparagraph and subject to sub-
9 section (d))’ were substituted for ‘(as defined in subpara-
10 graph (B))’ in subparagraph (A) of such section; and”.

11 (2) SPECIAL RULE.—With respect to California, sec-
12 tion 4721(e) of the Balanced Budget Act of 1997 (Public
13 Law 105–33; 111 Stat. 514) shall be applied without re-
14 gard to paragraph (1).

15 (3) PERIOD DESCRIBED.—The period described in this
16 paragraph is the period that begins, with respect to a
17 State, on the first day of the first State fiscal year that be-
18 gins after September 30, 2002, and ends on the last day
19 of the succeeding State fiscal year.

20 (4) APPLICATION TO WAIVERS.—With respect to a
21 State operating under a waiver of the requirements of title
22 XIX of the Social Security Act (42 U.S.C. 1396 et seq.)
23 under section 1115 of such Act (42 U.S.C. 1315), the
24 amount by which any payment adjustment made by the
25 State under title XIX of such Act (42 U.S.C. 1396 et seq.),
26 after the application of section 4721(e) of the Balanced
27 Budget Act of 1997 under paragraph (1) to such State, ex-
28 ceeds the costs of furnishing hospital services provided by
29 hospitals described in such section shall be fully reflected
30 as an increase in the baseline expenditure limit for such
31 waiver.

32 (d) ASSISTANCE FOR CERTAIN PUBLIC HOSPITALS.—

33 (1) IN GENERAL.—Beginning with fiscal year 2002,
34 notwithstanding section 1923(f) of the Social Security Act
35 (42 U.S.C. 1396r–4(f)) and subject to paragraph (3), with
36 respect to a State, payment adjustments made under title
37 XIX of the Social Security Act (42 U.S.C. 1396 et seq.)

1 to a hospital described in paragraph (2) shall be made
2 without regard to the DSH allotment limitation for the
3 State determined under section 1923(f) of that Act (42
4 U.S.C. 1396r-4(f)).

5 (2) HOSPITAL DESCRIBED.—A hospital is described in
6 this paragraph if the hospital—

7 (A) is owned or operated by a State (as defined
8 for purposes of title XIX of the Social Security Act),
9 or by an instrumentality or a unit of government within
10 a State (as so defined);

11 (B) as of October 1, 2000—

12 (i) is in existence and operating as a hospital
13 described in subparagraph (A); and

14 (ii) is not receiving disproportionate share hos-
15 pital payments from the State in which it is located
16 under title XIX of such Act; and

17 (C) has a low-income utilization rate (as defined in
18 section 1923(b)(3) of the Social Security Act (42
19 U.S.C. 1396r-4(b)(3))) in excess of 65 percent.

20 (3) LIMITATION ON EXPENDITURES.—

21 (A) IN GENERAL.—With respect to any fiscal year,
22 the aggregate amount of Federal financial participation
23 that may be provided for payment adjustments de-
24 scribed in paragraph (1) for that fiscal year for all
25 States may not exceed the amount described in sub-
26 paragraph (B) for the fiscal year.

27 (B) AMOUNT DESCRIBED.—The amount described
28 in this subparagraph for a fiscal year is as follows:

29 (i) For fiscal year 2002, \$15,000,000.

30 (ii) For fiscal year 2003, \$176,000,000.

31 (iii) For fiscal year 2004, \$269,000,000.

32 (iv) For fiscal year 2005, \$330,000,000.

33 (v) For fiscal year 2006 and each fiscal year
34 thereafter, \$375,000,000.

35 (e) DSH PAYMENT ACCOUNTABILITY STANDARDS.—Not
36 later than September 30, 2002, the Secretary of Health and
37 Human Services shall implement accountability standards to

1 ensure that Federal funds provided with respect to dispropor-
2 tionate share hospital adjustments made under section 1923 of
3 the Social Security Act (42 U.S.C. 1396r-4) are used to reim-
4 burse States and hospitals eligible for such payment adjust-
5 ments for providing uncompensated health care to low-income
6 patients and are otherwise made in accordance with the re-
7 quirements of section 1923 of that Act.

8 **SEC. 702. NEW PROSPECTIVE PAYMENT SYSTEM FOR**
9 **FEDERALLY-QUALIFIED HEALTH CENTERS**
10 **AND RURAL HEALTH CLINICS.**

11 (a) IN GENERAL.—Section 1902(a) (42 U.S.C. 1396a(a))
12 is amended—

13 (1) in paragraph (13)—

14 (A) in subparagraph (A), by adding “and” at the
15 end;

16 (B) in subparagraph (B), by striking “and” at the
17 end; and

18 (C) by striking subparagraph (C); and

19 (2) by inserting after paragraph (14) the following
20 new paragraph:

21 “(15) provide for payment for services described in
22 clause (B) or (C) of section 1905(a)(2) under the plan in
23 accordance with subsection (aa);”.

24 (b) NEW PROSPECTIVE PAYMENT SYSTEM.—Section 1902
25 (42 U.S.C. 1396a) is amended by adding at the end the fol-
26 lowing:

27 “(aa) PAYMENT FOR SERVICES PROVIDED BY FEDER-
28 ALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH
29 CLINICS.—

30 “(1) IN GENERAL.—Beginning with fiscal year 2001
31 and each succeeding fiscal year, the State plan shall pro-
32 vide for payment for services described in section
33 1905(a)(2)(C) furnished by a Federally-qualified health
34 center and services described in section 1905(a)(2)(B) fur-
35 nished by a rural health clinic in accordance with the provi-
36 sions of this subsection.

1 “(2) FISCAL YEAR 2001.—Subject to paragraph (4),
2 for services furnished during fiscal year 2001, the State
3 plan shall provide for payment for such services in an
4 amount (calculated on a per visit basis) that is equal to
5 100 percent of the average of the costs of the center or
6 clinic of furnishing such services during fiscal years 1999
7 and 2000 which are reasonable and related to the cost of
8 furnishing such services, or based on such other tests of
9 reasonableness as the Secretary prescribes in regulations
10 under section 1833(a)(3), or, in the case of services to
11 which such regulations do not apply, the same methodology
12 used under section 1833(a)(3), adjusted to take into ac-
13 count any increase or decrease in the scope of such services
14 furnished by the center or clinic during fiscal year 2001.

15 “(3) FISCAL YEAR 2002 AND SUCCEEDING FISCAL
16 YEARS.—Subject to paragraph (4), for services furnished
17 during fiscal year 2002 or a succeeding fiscal year, the
18 State plan shall provide for payment for such services in
19 an amount (calculated on a per visit basis) that is equal
20 to the amount calculated for such services under this sub-
21 section for the preceding fiscal year—

22 “(A) increased by the percentage increase in the
23 MEI (as defined in section 1842(i)(3)) applicable to
24 primary care services (as defined in section 1842(i)(4))
25 for that fiscal year; and

26 “(B) adjusted to take into account any increase or
27 decrease in the scope of such services furnished by the
28 center or clinic during that fiscal year.

29 “(4) ESTABLISHMENT OF INITIAL YEAR PAYMENT
30 AMOUNT FOR NEW CENTERS OR CLINICS.—In any case in
31 which an entity first qualifies as a Federally-qualified
32 health center or rural health clinic after fiscal year 2000,
33 the State plan shall provide for payment for services de-
34 scribed in section 1905(a)(2)(C) furnished by the center or
35 services described in section 1905(a)(2)(B) furnished by
36 the clinic in the first fiscal year in which the center or clin-
37 ic so qualifies in an amount (calculated on a per visit basis)

1 that is equal to 100 percent of the costs of furnishing such
2 services during such fiscal year based on the rates estab-
3 lished under this subsection for the fiscal year for other
4 such centers or clinics located in the same or adjacent area
5 with a similar case load or, in the absence of such a center
6 or clinic, in accordance with the regulations and method-
7 ology referred to in paragraph (2) or based on such other
8 tests of reasonableness as the Secretary may specify. For
9 each fiscal year following the fiscal year in which the entity
10 first qualifies as a Federally-qualified health center or rural
11 health clinic, the State plan shall provide for the payment
12 amount to be calculated in accordance with paragraph (3).

13 “(5) ADMINISTRATION IN THE CASE OF MANAGED
14 CARE.—

15 “(A) IN GENERAL.—In the case of services fur-
16 nished by a Federally-qualified health center or rural
17 health clinic pursuant to a contract between the center
18 or clinic and a managed care entity (as defined in sec-
19 tion 1932(a)(1)(B)), the State plan shall provide for
20 payment to the center or clinic by the State of a sup-
21 plemental payment equal to the amount (if any) by
22 which the amount determined under paragraphs (2),
23 (3), and (4) of this subsection exceeds the amount of
24 the payments provided under the contract.

25 “(B) PAYMENT SCHEDULE.—The supplemental
26 payment required under subparagraph (A) shall be
27 made pursuant to a payment schedule agreed to by the
28 State and the Federally-qualified health center or rural
29 health clinic, but in no case less frequently than every
30 4 months.

31 “(6) ALTERNATIVE PAYMENT METHODOLOGIES.—Not-
32 withstanding any other provision of this section, the State
33 plan may provide for payment in any fiscal year to a Fed-
34 erally-qualified health center for services described in sec-
35 tion 1905(a)(2)(C) or to a rural health clinic for services
36 described in section 1905(a)(2)(B) in an amount which is

1 determined under an alternative payment methodology
2 that—

3 “(A) is agreed to by the State and the center or
4 clinic; and

5 “(B) results in payment to the center or clinic of
6 an amount which is at least equal to the amount other-
7 wise required to be paid to the center or clinic under
8 this section.”.

9 (c) CONFORMING AMENDMENTS.—

10 (1) Section 4712 of the BBA (Public Law 105-33;
11 111 Stat. 508) is amended by striking subsection (c).

12 (2) Section 1915(b) (42 U.S.C. 1396n(b)) is amended
13 by striking “1902(a)(13)(C)” and inserting “1902(a)(15),
14 1902(aa),”.

15 (d) GAO STUDY OF FUTURE REBASING.—The Comp-
16 troller General of the United States shall provide for a study
17 on the need for, and how to, rebase or refine costs for making
18 payment under the medicaid program for services provided by
19 Federally-qualified health centers and rural health clinics (as
20 provided under the amendments made by this section). The
21 Comptroller General shall provide for submittal of a report on
22 such study to Congress by not later than 4 years after the date
23 of the enactment of this Act.

24 (e) EFFECTIVE DATE.—The amendments made by this
25 section take effect on October 1, 2000, and apply to services
26 furnished on or after such date.

27 **SEC. 703. STREAMLINED APPROVAL OF CONTINUED**
28 **STATE-WIDE SECTION 1115 MEDICAID WAIV-**
29 **ERS.**

30 (a) IN GENERAL.—Section 1115 (42 U.S.C. 1315) is
31 amended by adding at the end the following new subsection:

32 “(f) An application by the chief executive officer of a State
33 for an extension of a waiver project the State is operating
34 under an extension under subsection (e) (in this subsection re-
35 ferred to as the ‘waiver project’) shall be submitted and ap-
36 proved or disapproved in accordance with the following:

1 “(1) The application for an extension of the waiver
2 project shall be submitted to the Secretary at least 120
3 days prior to the expiration of the current period of the
4 waiver project.

5 “(2) Not later than 45 days after the date such appli-
6 cation is received by the Secretary, the Secretary shall no-
7 tify the State if the Secretary intends to review the terms
8 and conditions of the waiver project. A failure to provide
9 such notification shall be deemed to be an approval of the
10 application.

11 “(3) Not later than 45 days after the date a notifica-
12 tion is made in accordance with paragraph (2), the Sec-
13 retary shall inform the State of proposed changes in the
14 terms and conditions of the waiver project. A failure to pro-
15 vide such information shall be deemed to be an approval of
16 the application.

17 “(4) During the 30-day period that begins on the date
18 information described in paragraph (3) is provided to a
19 State, the Secretary shall negotiate revised terms and con-
20 ditions of the waiver project with the State.

21 “(5)(A) Not later than 120 days after the date an ap-
22 plication for an extension of the waiver project is submitted
23 to the Secretary (or such later date agreed to by the chief
24 executive officer of the State), the Secretary shall—

25 “(i) approve the application subject to such modi-
26 fications in the terms and conditions—

27 “(I) as have been agreed to by the Secretary
28 and the State; or

29 “(II) in the absence of such agreement, as are
30 determined by the Secretary to be reasonable, con-
31 sistent with the overall objectives of the waiver
32 project, and not in violation of applicable law; or

33 “(ii) disapprove the application.

34 “(B) A failure by the Secretary to approve or dis-
35 approve an application submitted under this subsection in
36 accordance with the requirements of subparagraph (A)
37 shall be deemed to be an approval of the application subject

1 to such modifications in the terms and conditions as have
2 been agreed to (if any) by the Secretary and the State.

3 “(6) An approval of an application for an extension of
4 a waiver project under this subsection shall be for a period
5 not to exceed 3 years.

6 “(7) An extension of a waiver project under this sub-
7 section shall be subject to the final reporting and evalua-
8 tion requirements of paragraphs (4) and (5) of subsection
9 (e) (taking into account the extension under this subsection
10 with respect to any timing requirements imposed under
11 those paragraphs).”.

12 (b) EFFECTIVE DATE.—The amendment made by sub-
13 section (a) applies to requests for extensions of demonstration
14 projects pending or submitted on or after the date of the enact-
15 ment of this Act.

16 **SEC. 704. MEDICAID COUNTY-ORGANIZED HEALTH SYS-**
17 **TEMS.**

18 (a) IN GENERAL.—Section 9517(c)(3)(C) of the Com-
19 prehensive Omnibus Budget Reconciliation Act of 1985 is
20 amended by striking “10 percent” and inserting “14 percent”.

21 (b) EFFECTIVE DATE.—The amendment made by sub-
22 section (a) takes effect on the date of the enactment of this
23 Act.

24 **SEC. 705. DEADLINE FOR ISSUANCE OF FINAL REGULA-**
25 **TION RELATING TO MEDICAID UPPER PAY-**
26 **MENT LIMITS.**

27 (a) IN GENERAL.—Not later than December 31, 2000, the
28 Secretary of Health and Human Services (in this section re-
29 ferred to as the “Secretary”), notwithstanding any requirement
30 of the Administrative Procedures Act under chapter 5 of title
31 5, United States Code, or any other provision of law, shall issue
32 under sections 447.272, 447.304, and 447.321 of title 42, Code
33 of Federal Regulations (and any other section of part 447 of
34 title 42, Code of Federal Regulations that the Secretary deter-
35 mines is appropriate), a final regulation based on the proposed
36 rule announced on October 5, 2000, that—

1 (1) modifies the upper payment limit test applied to
2 State medicaid spending for inpatient hospital services, out-
3 patient hospital services, nursing facility services, inter-
4 mediate care facility services for the mentally retarded, and
5 clinic services by applying an aggregate upper payment
6 limit to payments made to government facilities that are
7 not State-owned or operated facilities; and

8 (2) provides for a transition period in accordance with
9 subsection (b).

10 (b) TRANSITION PERIOD.—

11 (1) IN GENERAL.—The final regulation required under
12 subsection (a) shall provide that, with respect to a State
13 described in paragraph (3), the State shall be considered
14 to be in compliance with the final regulation required under
15 subsection (a) so long as, for each State fiscal year during
16 the period described in paragraph (4), the State reduces
17 payments under a State medicaid plan payment provision
18 or methodology described in paragraph (3), or reduces the
19 actual dollar payment levels described in paragraph (3)(B),
20 so that the amount of the payments that would otherwise
21 have been made under such provision, methodology, or pay-
22 ment levels by the State for any State fiscal year during
23 such period is reduced by 15 percent in the first such State
24 fiscal year, and by an additional 15 percent in each of next
25 5 State fiscal years.

26 (2) REQUIREMENT.—Notwithstanding paragraph (1),
27 the final regulation required under subsection (a) shall pro-
28 vide that, for any period (or portion of a period) that oc-
29 curs on or after October 1, 2008, medicaid payments made
30 by a State described in paragraph (3) shall comply with
31 such final regulation.

32 (3) STATE DESCRIBED.—A State described in this
33 paragraph is a State with a State medicaid plan payment
34 provision or methodology which—

35 (A) was approved, deemed to have been approved,
36 or was in effect on or before October 1, 1992 (includ-
37 ing any subsequent amendments or successor provisions

1 or methodologies and whether or not a State plan
 2 amendment was made to carry out such provision or
 3 methodology after such date) or under which claims for
 4 Federal financial participation were filed and paid on
 5 or before such date; and

6 (B) provides for payments that are in excess of the
 7 upper payment limit test established under the final
 8 regulation required under subsection (a) (or which
 9 would be noncompliant with such final regulation if the
 10 actual dollar payment levels made under the payment
 11 provision or methodology in the State fiscal year which
 12 begins during 1999 were continued).

13 (4) PERIOD DESCRIBED.—The period described in this
 14 paragraph is the period that begins on the first State fiscal
 15 year that begins after September 30, 2002, and ends on
 16 September 30, 2008.

17 **SEC. 706. ALASKA FMAP.**

18 Notwithstanding the first sentence of section 1905(b) of
 19 the Social Security Act (42 U.S.C. 1396d(b)), only with respect
 20 to each of fiscal years 2001 through 2005, for purposes of ti-
 21 tles XIX and XXI of the Social Security Act, the State percent-
 22 age used to determine the Federal medical assistance percent-
 23 age for Alaska shall be that percentage which bears the same
 24 ratio to 45 percent as the square of the adjusted per capita in-
 25 come of Alaska (determined by dividing the State's 3-year aver-
 26 age per capita income by 1.05) bears to the square of the per
 27 capita income of the 50 States.

28 **TITLE VIII—STATE CHILDREN'S**
 29 **HEALTH INSURANCE PROGRAM**

30 **SEC. 801. SPECIAL RULE FOR REDISTRIBUTION AND**
 31 **AVAILABILITY OF UNUSED FISCAL YEAR 1998**
 32 **AND 1999 SCHIP ALLOTMENTS.**

33 (a) CHANGE IN RULES FOR REDISTRIBUTION AND RE-
 34 TENTION OF UNUSED SCHIP ALLOTMENTS FOR FISCAL
 35 YEARS 1998 AND 1999.—Section 2104 (42 U.S.C. 1397dd) is
 36 amended by adding at the end the following new subsection:

1 “(g) RULE FOR REDISTRIBUTION AND EXTENDED AVAIL-
2 ABILITY OF FISCAL YEARS 1998 AND 1999 ALLOTMENTS.—

3 “(1) AMOUNT REDISTRIBUTED.—

4 “(A) IN GENERAL.—In the case of a State that
5 expends all of its allotment under subsection (b) or (c)
6 for fiscal year 1998 by the end of fiscal year 2000, or
7 for fiscal year 1999 by the end of fiscal year 2001, the
8 Secretary shall redistribute to the State under sub-
9 section (f) (from the fiscal year 1998 or 1999 allot-
10 ments of other States, respectively, as determined by
11 the application of paragraphs (2) and (3) with respect
12 to the respective fiscal year)) the following amount:

13 “(i) STATE.—In the case of 1 of the 50 States
14 or the District of Columbia, with respect to—

15 “(I) the fiscal year 1998 allotment, the
16 amount by which the State’s expenditures
17 under this title in fiscal years 1998, 1999, and
18 2000 exceed the State’s allotment for fiscal
19 year 1998 under subsection (b); or

20 “(II) the fiscal year 1999 allotment, the
21 amount by which the State’s expenditures
22 under this title in fiscal years 1999, 2000, and
23 2001 exceed the State’s allotment for fiscal
24 year 1999 under subsection (b).

25 “(ii) TERRITORY.—In the case of a common-
26 wealth or territory described in subsection (c)(3),
27 an amount that bears the same ratio to 1.05 per-
28 cent of the total amount described in paragraph
29 (2)(B)(i)(I) as the ratio of the commonwealth’s or
30 territory’s fiscal year 1998 or 1999 allotment
31 under subsection (c) (as the case may be) bears to
32 the total of all such allotments for such fiscal year
33 under such subsection.

34 “(B) EXPENDITURE RULES.—An amount redis-
35 tributed to a State under this paragraph with respect
36 to fiscal year 1998 or 1999—

1 “(i) shall not be included in the determination
2 of the State’s allotment for any fiscal year under
3 this section;

4 “(ii) notwithstanding subsection (e), shall re-
5 main available for expenditure by the State through
6 the end of fiscal year 2002; and

7 “(iii) shall be counted as being expended with
8 respect to a fiscal year allotment in accordance
9 with applicable regulations of the Secretary.

10 “(2) EXTENSION OF AVAILABILITY OF PORTION OF
11 UNEXPENDED FISCAL YEARS 1998 AND 1999 ALLOT-
12 MENTS.—

13 “(A) IN GENERAL.—Notwithstanding subsection
14 (e):

15 “(i) FISCAL YEAR 1998 ALLOTMENT.—Of the
16 amounts allotted to a State pursuant to this section
17 for fiscal year 1998 that were not expended by the
18 State by the end of fiscal year 2000, the amount
19 specified in subparagraph (B) for fiscal year 1998
20 for such State shall remain available for expendi-
21 ture by the State through the end of fiscal year
22 2002.

23 “(ii) FISCAL YEAR 1999 ALLOTMENT.—Of the
24 amounts allotted to a State pursuant to this sub-
25 section for fiscal year 1999 that were not expended
26 by the State by the end of fiscal year 2001, the
27 amount specified in subparagraph (B) for fiscal
28 year 1999 for such State shall remain available for
29 expenditure by the State through the end of fiscal
30 year 2002.

31 “(B) AMOUNT REMAINING AVAILABLE FOR EX-
32 PENDITURE.—The amount specified in this subpara-
33 graph for a State for a fiscal year is equal to—

34 “(i) the amount by which (I) the total amount
35 available for redistribution under subsection (f)
36 from the allotments for that fiscal year, exceeds

1 (II) the total amounts redistributed under para-
2 graph (1) for that fiscal year; multiplied by

3 “(ii) the ratio of the amount of such State’s
4 unexpended allotment for that fiscal year to the
5 total amount described in clause (i)(I) for that fis-
6 cal year.

7 “(C) USE OF UP TO 10 PERCENT OF RETAINED
8 1998 ALLOTMENTS FOR OUTREACH ACTIVITIES.—Not-
9 withstanding section 2105(c)(2)(A), with respect to any
10 State described in subparagraph (A)(i), the State may
11 use up to 10 percent of the amount specified in sub-
12 subparagraph (B) for fiscal year 1998 for expenditures for
13 outreach activities approved by the Secretary.

14 “(3) DETERMINATION OF AMOUNTS.—For purposes of
15 calculating the amounts described in paragraphs (1) and
16 (2) relating to the allotment for fiscal year 1998 or fiscal
17 year 1999, the Secretary shall use the amounts reported by
18 the States not later than November 30, 2000, or November
19 30, 2001, respectively, on HCFA Form 64 or HCFA Form
20 21, as approved by the Secretary.”.

21 (b) EFFECTIVE DATE.—The amendments made by this
22 section shall take effect as if included in the enactment of sec-
23 tion 4901 of BBA (111 Stat. 552).

24 **SEC. 802. AUTHORITY TO PAY MEDICAID EXPANSION**
25 **SCHIP COSTS FROM TITLE XXI APPROPRIA-**
26 **TION.**

27 (a) AUTHORITY TO PAY MEDICAID EXPANSION SCHIP
28 COSTS FROM TITLE XXI APPROPRIATION.—Section 2105(a)
29 (42 U.S.C. 1397ee(a)) is amended—

30 (1) by redesignating subparagraphs (A) through (D)
31 of paragraph (2) as clauses (i) through (iv), respectively,
32 and indenting appropriately;

33 (2) by redesignating paragraph (1) as subparagraph
34 (C), and indenting appropriately;

35 (3) by redesignating paragraph (2) as subparagraph
36 (D), and indenting appropriately;

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1 (4) by striking “(a) IN GENERAL.—” and the remain-
2 der of the text that precedes subparagraph (C), as so re-
3 designated, and inserting the following:

4 “(a) PAYMENTS.—

5 “(1) IN GENERAL.—Subject to the succeeding provi-
6 sions of this section, the Secretary shall pay to each State
7 with a plan approved under this title, from its allotment
8 under section 2104, an amount for each quarter equal to
9 the enhanced FMAP (or, in the case of expenditures de-
10 scribed in subparagraph (B), the Federal medical assist-
11 ance percentage (as defined in the first sentence of section
12 1905(b))) of expenditures in the quarter—

13 “(A) for child health assistance under the plan for
14 targeted low-income children in the form of providing
15 medical assistance for which payment is made on the
16 basis of an enhanced FMAP under the fourth sentence
17 of section 1905(b);

18 “(B) for the provision of medical assistance on be-
19 half of a child during a presumptive eligibility period
20 under section 1920A;” and

21 (5) by adding after subparagraph (D), as so redesign-
22 ated, the following new paragraph:

23 “(2) ORDER OF PAYMENTS.—Payments under para-
24 graph (1) from a State’s allotment shall be made in the fol-
25 lowing order:

26 “(A) First, for expenditures for items described in
27 paragraph (1)(A).

28 “(B) Second, for expenditures for items described
29 in paragraph (1)(B).

30 “(C) Third, for expenditures for items described in
31 paragraph (1)(C).

32 “(D) Fourth, for expenditures for items described
33 in paragraph (1)(D).”.

34 (b) ELIMINATION OF REQUIREMENT TO REDUCE TITLE
35 XXI ALLOTMENT BY MEDICAID EXPANSION SCHIP COSTS.—
36 Section 2104 (42 U.S.C. 1397dd) is amended by striking sub-
37 section (d).

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1 (c) AUTHORITY TO TRANSFER TITLE XXI APPROPRIA-
2 TIONS TO TITLE XIX APPROPRIATION ACCOUNT AS REIM-
3 BURSEMENT FOR MEDICAID EXPENDITURES FOR MEDICAID
4 EXPANSION SCHIP SERVICES.—Notwithstanding any other
5 provision of law, all amounts appropriated under title XXI and
6 allotted to a State pursuant to subsection (b) or (c) of section
7 2104 of the Social Security Act (42 U.S.C. 1397dd) for fiscal
8 years 1998 through 2000 (including any amounts that, but for
9 this provision, would be considered to have expired) and not ex-
10 pended in providing child health assistance or related services
11 for which payment may be made pursuant to subparagraph (C)
12 or (D) of section 2105(a)(1) of such Act (42 U.S.C.
13 1397ee(a)(1)) (as amended by subsection (a)), shall be avail-
14 able to reimburse the Grants to States for Medicaid account in
15 an amount equal to the total payments made to such State
16 under section 1903(a) of such Act (42 U.S.C. 1396b(a)) for ex-
17 penditures in such years for medical assistance described in
18 subparagraphs (A) and (B) of section 2105(a)(1) of such Act
19 (42 U.S.C. 1397ee(a)(1) (as so amended).

20 (d) CONFORMING AMENDMENTS.—

21 (1) Section 1905(b) (42 U.S.C. 1396d(b)) is amended
22 in the fourth sentence by striking “the State’s allotment
23 under section 2104 (not taking into account reductions
24 under section 2104(d)(2)) for the fiscal year reduced by the
25 amount of any payments made under section 2105 to the
26 State from such allotment for such fiscal year” and insert-
27 ing “the State’s available allotment under section 2104”.

28 (2) Section 1905(u)(1)(B) (42 U.S.C.
29 1396d(u)(1)(B)) is amended by striking “and section
30 2104(d)”.

31 (3) Section 2104 (42 U.S.C. 1397dd), as amended by
32 subsection (b), is further amended—

33 (A) in subsection (b)(1), by striking “and sub-
34 section (d)”;

35 (B) in subsection (c)(1), by striking “subject to
36 subsection (d),”.

1 (4) Section 2105(c) (42 U.S.C. 1397ee(c)) is
2 amended—

3 (A) in paragraph (2)(A), by striking all that fol-
4 lows “Except as provided in this paragraph,” and in-
5 serting “the amount of payment that may be made
6 under subsection (a) for a fiscal year for expenditures
7 for items described in paragraph (1)(D) of such sub-
8 section shall not exceed 10 percent of the total amount
9 of expenditures for which payment is made under sub-
10 paragraphs (A), (C), and (D) of paragraph (1) of such
11 subsection.”;

12 (B) in paragraph (2)(B), by striking “described in
13 subsection (a)(2)” and inserting “described in sub-
14 section (a)(1)(D)”;

15 (C) in paragraph (6)(B), by striking “Except as
16 otherwise provided by law,” and inserting “Except as
17 provided in subparagraph (A) or (B) of subsection
18 (a)(1) or any other provision of law,”.

19 (5) Section 2110(a) (42 U.S.C. 1397jj(a)) is amended
20 by striking “section 2105(a)(2)(A)” and inserting “section
21 2105(a)(1)(D)(i)”.

22 (e) TECHNICAL AMENDMENT.—Section 2105(d)(2)(B)(ii)
23 (42 U.S.C. 1397ee(d)(2)(B)(ii)) is amended by striking “en-
24 hanced FMAP under section 1905(u)” and inserting “enhanced
25 FMAP under the fourth sentence of section 1905(b)”.

26 (f) EFFECTIVE DATE.—The amendments made by this
27 section shall be effective as if included in the enactment of sec-
28 tion 4901 of the BBA (111 Stat. 552).

29 **TITLE IX—OTHER PROVISIONS**

30 **Subtitle A—PACE Program**

31 **SEC. 901. EXTENSION OF TRANSITION FOR CURRENT**

32 **WAIVERS.**

33 Section 4803(d)(2) of BBA is amended—

34 (1) in subparagraph (A), by striking “24 months” and
35 inserting “36 months”;

1 (2) in subparagraph (A), by striking “the initial effective
2 date of regulations described in subsection (a)” and inserting
3 “July 1, 2000”; and

4 (3) in subparagraph (B), by striking “3 years” and inserting
5 “4 years”.

6 **SEC. 902. CONTINUING OF CERTAIN OPERATING ARRANGEMENTS PERMITTED.**
7

8 (a) IN GENERAL.—Section 1894(f)(2) (42 U.S.C. 1395eee(f)(2)) is amended by adding at the end the following
9 new subparagraph:
10

11 “(C) CONTINUATION OF MODIFICATIONS OR WAIVERS OF OPERATIONAL REQUIREMENTS UNDER DEMONSTRATION STATUS.—If a PACE program operating
12 under demonstration authority has contractual or other
13 operating arrangements which are not otherwise recognized in regulation and which were in effect on July 1,
14 2000, the Secretary (in close consultation with, and
15 with the concurrence of, the State administering agency) shall permit any such program to continue such arrangements
16 so long as such arrangements are found by
17 the Secretary and the State to be reasonably consistent
18 with the objectives of the PACE program.”.

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21
22
23 (b) CONFORMING AMENDMENT.—Section 1934(f)(2) (42
24 U.S.C. 1396u-4(f)(2)) is amended by adding at the end the following new subparagraph:
25

26 “(C) CONTINUATION OF MODIFICATIONS OR WAIVERS OF OPERATIONAL REQUIREMENTS UNDER DEMONSTRATION STATUS.—If a PACE program operating
27 under demonstration authority has contractual or other
28 operating arrangements which are not otherwise recognized in regulation and which were in effect on July 1
29 2000, the Secretary (in close consultation with, and
30 with the concurrence of, the State administering agency) shall permit any such program to continue such arrangements
31 so long as such arrangements are found by
32 the Secretary and the State to be reasonably consistent
33 with the objectives of the PACE program.”.

1 (c) EFFECTIVE DATE.—The amendments made by this
 2 section shall be effective as included in the enactment of BBA.
 3 **SEC. 903. FLEXIBILITY IN EXERCISING WAIVER AUTHOR-**
 4 **ITY.**

5 In applying sections 1894(f)(2)(B) and 1934(f)(2)(B) of
 6 the Social Security Act (42 U.S.C. 1395eee(f)(2)(B), 1396u-
 7 4(f)(2)(B)), the Secretary of Health and Human Services—

8 (1) shall approve or deny a request for a modification
 9 or a waiver of provisions of the PACE protocol not later
 10 than 90 days after the date the Secretary receives the re-
 11 quest; and

12 (2) may exercise authority to modify or waive such
 13 provisions in a manner that responds promptly to the needs
 14 of PACE programs relating to areas of employment and
 15 the use of community-based primary care physicians.

16 **Subtitle B—Outreach to Eligible Low-**
 17 **Income Medicare Beneficiaries**

18 **SEC. 911. OUTREACH ON AVAILABILITY OF MEDICARE**
 19 **COST-SHARING ASSISTANCE TO ELIGIBLE**
 20 **LOW-INCOME MEDICARE BENEFICIARIES.**

21 (a) OUTREACH.—

22 (1) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.)
 23 is amended by inserting after section 1143 the following
 24 new section:

25 “OUTREACH EFFORTS TO INCREASE AWARENESS OF THE
 26 AVAILABILITY OF MEDICARE COST-SHARING

27 “SEC. 1144. (a) OUTREACH.—

28 “(1) IN GENERAL.—The Commissioner of Social Secu-
 29 rity (in this section referred to as the ‘Commissioner’) shall
 30 conduct outreach efforts to—

31 “(A) identify individuals entitled to benefits under
 32 the medicare program under title XVIII who may be el-
 33 igible for medical assistance for payment of the cost of
 34 medicare cost-sharing under the medicaid program pur-
 35 suant to sections 1902(a)(10)(E) and 1933; and

36 “(B) notify such individuals of the availability of
 37 such medical assistance under such sections.

185

1 “(2) CONTENT OF NOTICE.—Any notice furnished
2 under paragraph (1) shall state that eligibility for medicare
3 cost-sharing assistance under such sections is conditioned
4 upon—

5 “(A) the individual providing to the State informa-
6 tion about income and resources (in the case of an indi-
7 vidual residing in a State that imposes an assets test
8 for such eligibility); and

9 “(B) meeting the applicable eligibility criteria.

10 “(b) COORDINATION WITH STATES.—

11 “(1) IN GENERAL.—In conducting the outreach efforts
12 under this section, the Commissioner shall—

13 “(A) furnish the agency of each State responsible
14 for the administration of the medicaid program and
15 any other appropriate State agency with information
16 consisting of the name and address of individuals resid-
17 ing in the State that the Commissioner determines may
18 be eligible for medical assistance for payment of the
19 cost of medicare cost-sharing under the medicaid pro-
20 gram pursuant to sections 1902(a)(10)(E) and 1933;
21 and

22 “(B) update any such information not less fre-
23 quently than once per year.

24 “(2) INFORMATION IN PERIODIC UPDATES.—The peri-
25 odic updates described in paragraph (1)(B) shall include in-
26 formation on individuals who are or may be eligible for the
27 medical assistance described in paragraph (1)(A) because
28 such individuals have experienced reductions in benefits
29 under title II.”.

30 (2) AMENDMENT TO TITLE XIX.—Section 1905(p) (42
31 U.S.C. 1396d(p)) is amended by adding at the end the fol-
32 lowing new paragraph:

33 “(5) For provisions relating to outreach efforts to increase
34 awareness of the availability of medicare cost-sharing, see sec-
35 tion 1144.”.

36 (b) GAO REPORT.—The Comptroller General of the
37 United States shall conduct a study of the impact of section

1 1144 of the Social Security Act (as added by subsection (a)(1))
2 on the enrollment of individuals for medicare cost-sharing
3 under the medicaid program. Not later than 18 months after
4 the date that the Commissioner of Social Security first con-
5 ducts outreach under section 1144 of such Act, the Comptroller
6 General shall submit to Congress a report on such study. The
7 report shall include such recommendations for legislative
8 changes as the Comptroller General deems appropriate.

9 (c) EFFECTIVE DATE.—The amendments made by sub-
10 sections (a) shall take effect one year after the date of the en-
11 actment of this Act.

12 **Subtitle C—Maternal and Child** 13 **Health Block Grant**

14 **SEC. 921. INCREASE IN AUTHORIZATION OF APPROPRIA-** 15 **TIONS FOR THE MATERNAL AND CHILD** 16 **HEALTH SERVICES BLOCK GRANT.**

17 (a) IN GENERAL.—Section 501(a) (42 U.S.C. 701(a)) is
18 amended in the matter preceding paragraph (1) by striking
19 “\$705,000,000 for fiscal year 1994” and inserting
20 “\$850,000,000 for fiscal year 2001”.

21 (b) EFFECTIVE DATE.—The amendment made by sub-
22 section (a) takes effect on October 1, 2000.

23 **Subtitle D—Diabetes**

24 **SEC. 931. INCREASE IN APPROPRIATIONS FOR SPECIAL** 25 **DIABETES PROGRAMS FOR TYPE I DIABETES** 26 **AND INDIANS.**

27 (a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIABE-
28 TES.—Section 330B(b) of the Public Health Service Act (42
29 U.S.C. 254c-2(b)) is amended—

30 (1) by striking “Notwithstanding” and inserting the
31 following:

32 “(1) TRANSFERRED FUNDS.—Notwithstanding”; and

33 (2) by adding at the end the following:

34 “(2) APPROPRIATIONS.—For the purpose of making
35 grants under this section, there is appropriated, out of any
36 funds in the Treasury not otherwise appropriated—

1 “(A) \$70,000,000 for each of fiscal years 2001
2 and 2002 (which shall be combined with amounts
3 transferred under paragraph (1) for each such fiscal
4 years); and

5 “(B) \$100,000,000 for fiscal year 2003.”.

6 (b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—Sec-
7 tion 330C(c) of such Act (42 U.S.C. 254c-3(c)) is amended—

8 (1) by striking “Notwithstanding” and inserting the
9 following:

10 “(1) TRANSFERRED FUNDS.—Notwithstanding”; and

11 (2) by adding at the end the following:

12 “(2) APPROPRIATIONS.—For the purpose of making
13 grants under this section, there is appropriated, out of any
14 money in the Treasury not otherwise appropriated—

15 “(A) \$70,000,000 for each of fiscal years 2001
16 and 2002 (which shall be combined with amounts
17 transferred under paragraph (1) for each such fiscal
18 years); and

19 “(B) \$100,000,000 for fiscal year 2003.”.

20 (c) EXTENSION OF FINAL REPORT ON GRANT PRO-
21 GRAMS.—Section 4923(b)(2) of BBA is amended by striking
22 “2002” and inserting “2003”.

23 **SEC. 932. APPROPRIATIONS FOR RICKY RAY HEMO-**
24 **PHILIA RELIEF FUND.**

25 Section 101(e) of the Ricky Ray Hemophilia Relief Fund
26 Act of 1998 (42 U.S.C. 300c-22 note) is amended by adding
27 at the end the following: “There is appropriated to the Fund
28 \$475,000,000 for fiscal year 2001, to remain available until ex-
29 pended.”.